STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEATLH
FACILITY LICENSING AND INVESTIGATIONS SECTION

IN RE: Yale New Haven Hospital, Inc of New Haven d/b/a
Yale New Haven Hospital
20 York Street
New Haven, CT 06504

CONSENT AGREEMENT

WHEREAS, Yale New Haven Hospital, Inc of New Haven (hereinafter the "Licensee'), has been issued License No. 0044 to operate a General Hospital known as Yale New Haven Hospital, (hereinafter the "Facility") under Connecticut General Statutes Section 19a-490 by the Department of Public Health, State of Connecticut (hereinafter the "Department"); and

WHEREAS, the Facility Licensing and Investigations Section (hereinafter the "FLIS") of the Department conducted unannounced inspections on various dates including August of 2007, as well as inspections commencing on November 28, 2007 which concluded on March 18, 2008; and

WHEREAS, the Department, during the course of the aforementioned inspections identified violations with the Connecticut General Statutes and/or Regulations of Connecticut State Agencies in amended violation letter dated April 29, 2008 (Exhibit A – copy attached); and

WHEREAS, an office conference with respect to violation letter dated April 29, 2008 was held between the Department and the Licensee on May 19, 2008 at the office of the FLIS of the Department; and

WHEREAS, the Licensee is willing into enter into this Consent Agreement and agrees to the conditions set forth herein.

WHEREAS, the Licensee has implemented changes in response to concerns expressed by the Department; and

NOW THEREFORE, the Facility Licensing and Investigations Section of the Department, acting herein and through Joan Leavitt, its Section Chief, and the Licensee, acting through Richard D'Aquila, its Chief Operating Officer (COO), hereby stipulate and agree as follows:

1. Within fourteen (14) days of the execution of this Consent Agreement, the Facility agrees to develop and/or review and revise, as applicable, policies related to:
    a. Preventative skin care;
    b. Pressure ulcer and wound assessments;
    c. Operating room accounting practices for equipment and devices inclusive of sponges, sharps and instrument counts;
    d. Nutritional assessments and/or weight recommendations;
    e. Pain assessments and/or reassessments;
    f. Restraint use in accordance with federal and state laws and regulations;
    g. Neurological assessments;
    h. Monitoring and/or assessments of patients in labor/delivery;
    i. Infection control practices; and
    j. Medication administration.
2. The Facility shall provide inservices for Facility nursing staff, as applicable, regarding policies and procedures identified in paragraph one (1) within thirty days (30) days of the approval of said revised policies and procedures.
3. The Licensee shall continue to employ a Wound Care Specialist (WCS).
4. The WCS shall have the responsibility for:
    a. Assessing, monitoring of patients at risk for and/or with actual pressure ulcers, evaluating the delivery of direct patient care with particular emphasis and focus on the delivery of nursing services by registered nurses, licensed practical nurses and nurse aides; and
    b. Implementing prompt training and/or remediation in areas related to skin integrity issues in which a staff member demonstrated a deficit. Records of said training and/or remediation shall be maintained by the Licensee for review by the Department for a minimum of three (3) years.

5. The Licensee shall continue to employ sufficient full time Infection Control Nurses (ICNs) whose sole responsibilities are to implement infection prevention, surveillance and control programs. The RNs employed as ICNs shall have additional credentials and training in infection control. The ICNs shall implement the following:
    a. Maintenance of an effective infection control program;
    b. Review and/or revise, as necessary, Facility policies/procedures pursuant to infection control/prevention;
    c. Inservice staff pursuant to infection control principles and practices;
    d. Develop policies and procedures relative to comprehensive infection control and employee health and/or specific criteria for the identification of health care associated infections and required precautions techniques; and
    e. Implement surveillance of staff in all areas of the Facility including, but no limited to, operating rooms and nursing units to ensure substantial compliance with appropriate Infection Control Guidelines and/or Facility Infection Control policies and procedures.
6. Within fourteen (14) days of the execution of this Consent Agreement, the Licensee shall appoint a Quality Compliance Monitor (QCM), who shall be responsible for reviewing, developing and implementing policies, procedures and practices designed to ensure compliance with all applicable state and federal laws and regulations within the purview of the Department of Public Health.
    a. The Quality Compliance Monitor (QCM) shall submit bi-monthly reports regarding the matters set forth above which will be submitted to the Governing Body. The QCM shall not serve as the Hospital's Counsel or Chief Financial Officer. The QCM shall be responsible for monitoring the day-to-day activities of the Facility to further compliance objectives and also to ensure that problems are being appropriately addressed and corrected.
7. Within thirty (30) days of the execution of this Consent Agreement, the Licensee shall establish a Quality Assurance Compliance Committee (hereinafter

"Compliance Committee"). The purpose of this Compliance Committee shall be to address issues inclusive of those identified in the April 29, 2008, violation letter issued by the Department. The Compliance Committee shall include, among others, the QCM and representatives from senior management responsible for clinical operations and Quality of Care. The Compliance Committee shall meet, at a minimum, every three (3) months and shall report regularly to the Hospital Board of Trustees' Committee on Quality and Patient Safety.

8. Within forty-five (45) of the execution of this Consent Agreement, the Compliance Committee shall:
    a. Review the adequacy of the Facility's internal systems, quality assurance monitoring and patient care; and
    b. Ensure that the Facility's response to quality of care issues resolves the issues(s) identified.
9. The Licensee shall maintain documentation of any committee meetings or reports as specified in paragraphs 6 and 7. Said documents shall be available to the Department and shall be retained for a period of three (3) years.
10. The Licensee shall incorporate into the Quality Assurance Program, indicators to analyze, date and track issues which have been identified as a result of the ongoing activities as described in paragraph 6 and 7.
11. Effective upon the execution of this Consent Agreement, the Licensee through its Chief Executive Officer and Board of Trustees shall ensure substantial compliance with the following:
    a. Treatments, therapies and administration of medications are provided are prescribed by the physician and in accordance with each patient's comprehensive care plan;
    b. Patient assessments, including, but not limited to, skin assessments and neurological assessments are performed in a timely manner, documented and accurately reflect the condition of the patient;
    c. Restraints are implemented in accordance with applicable federal and state laws and regulations;

d. Each patient care plan is reviewed and revised to reflect the individual patient's problem, needs and goals, based upon the patient assessment and in accordance with applicable federal and state laws and regulations;
e. Patients are provided with the necessary nutritional support, as applicable, to prevent significant weight loss;
f. Patients' with pressure sores and/or impaired skin integrity are provided with the necessary care to treat and prevent pressure sores and/or impaired skin integrity. Wounds, including pressure sores, are monitored and assessed in accordance with current regulations and standards of practice;
g. Necessary pressure relieving devices are provided to patients at risk for and/or with actual skin impairment;
h. Operating room practices, inclusive of maintaining accurate accounting of sponge, sharps and instrument are implemented and monitored; and
i. Patient assessments and patient monitoring are instituted and documented according to Facility policies and procedures within the labor and delivery units.

12. Within seven (7) days of the execution of this document, the Licensee shall provide the Department with the name of the Quality Compliance Monitor who shall be designated to monitor the requirements of the Consent Agreement.
13. The Quality Compliance Monitor shall meet with the Department every six (6) weeks for the first three (3) months after the execution of this Agreement and thereafter at twelve (12) week intervals throughout the term of this Consent Agreement. The meetings shall include discussions of issues related to the care and services provided by the Licensee and the Licensee's compliance with the terms of this Consent Agreement.
14. The Licensee shall pay a monetary penalty to the Department in the amount of eight thousand dollars ($8,000.00) by money order or bank check payable to the Treasurer of the State of Connecticut and mailed to the Department within two (2) weeks of the effective date of the Consent Agreement. The money penalty and any reports required by this document shall be directed to:

Diane Smith, R.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, MS #12FLIS
P.O. Box 340308
Hartford, CT 06134-0308

15. All parties agree that this Consent Agreement is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of the Consent Agreement or of any other statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, including any other administrative and judicial relief provided by law. This Consent Agreement may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law.
16. The terms of this Consent Agreement shall remain in effect for a period of two (2) years from the effective date of this document unless otherwise specified in this Agreement.
17. By entering into this Agreement, the Licensee is not admitting any wrongdoing.
18. The Licensee understands that this Consent Agreement and the terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum including any right to review under the Uniform Administrative Procedure Act, Chapter 368a of the Statutes, Regulations that exists at the time the agreement is executed or may become available in the future, provided that this stipulation shall not deprive the Licensee of any other rights that it may have under the laws of the State of Connecticut or of the United States.
19. The Licensee had the opportunity to consult with any attorney prior to the execution of this Consent Agreement.

Licensee: Yale New Haven Hospital, Inc of New Haven

WITNESS WHEREOF, the parties hereto have caused this Consent Agreement to be executed by their respective officers and officials, which Consent Agreement is to be effective as of the later of the two dates noted below.

Yale New Haven Hospital, Inc of New Haven - Licensee

9/24/08
Date

By: _____
Richard D'Aquila, COO

STATE OF CONNECTICUT)

County of New Haven) ss 9/24/ 2008

Personally appeared the above named RICHARD D'AQUILA and made oath to the truth of the statements contained herein.

My Commission Expires: _____
(If Notary Public)

Patricia C. Florentino
NOTARY PUBLIC
MY COMMISSION EXPIRES DEC 31, 2009

_____
Notary Public [ ]
Justice of the Peace [ ]
Town Clerk [ ]
Commissioner of the Superior Court [ ]

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

9/30/08
Date

By: _____
Joan D. Leavitt, R.N., M.S., Section Chief
Facility Licensing and Investigations Section

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
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April 29, 2008

Marna P. Borgstrom, President & CEO
Yale-New Haven Hospital
20 York St.
New Haven, CT 06504

Dear Ms. Borgstrom:

Unannounced visits were made to Yale-New Haven Hospital that concluded on March 18, 2008 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensing renewal inspection, to conduct a substantial allegation survey and full survey at the request of CMS and to conduct multiple investigations.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

An office conference has been scheduled for May 19, 2008, 1PM, Room 2E in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

Please prepare a written Plan of Correction for the above mentioned violations to be presented at this conference.

Each violation must be addressed with a prospective Plan of Correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).
2. Date corrective measure will be effected.
3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Ann Marie Montemerlo, RN
Supervising Nurse Consultant
Facility Licensing and Investigations Section

AMM:zbj

c. Director of Nurses
Medical Director
President
Complaints #6806, #6605, #6317, #6957, #6604
#6794, #6567, #6841, #7006, #7354, #7133
#7311, #7358, #7417, #7686, #7299, #7345
#7413, #7601

Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical staff (2)(B) and/or (4)(A) and/or (d) Medical records (3).

1. Based on review of the clinical record, review of facility policies, and staff interviews, the facility failed to initiate appropriate action that included supporting documentation when one patient, Patient #7, was detained in the Emergency Department's locked Crisis Intervention Unit (CIU) following a psychiatric evaluation. The findings included:
   a. Patient #7 arrived at the Emergency Department (ED) via ambulance at approximately 12:08 AM on 1/7/07 with complaints of increased depression. Patient #7 identified that she had spoken to an on call physician at approximately 11:30 PM on 1/6/07 because she felt she was having a reaction to her current antidepressants and that the on call physician had called an ambulance so that she could be seen in the ED. During the triage process, Patient #7 expressed having thoughts of suicide over the previous two to three days but that "I'm not going to do it." Patient #7 was evaluated by the ED physician, medically cleared, and remained in the ED with a sitter until the patient was transferred to the Intensive Observation Unit (IOU) at 6:32 AM. Review of an evaluation by MD #14 at 12:35 PM on 1/7/07 identified that Patient #7 had a history of a Bipolar Disorder and expressed thoughts of taking extra doses of her prescribed benzodiazepine associated with thoughts of suicide but that the patient reported that she did not feel that she could actually do it. The evaluation described Patient #7 as tearful with a depressed mood. The documentation identified that with Patient #7's permission, a friend of the patient's was called who confirmed Patient #7's recent decompensation of mood. In addition, a call was placed to Patient #7's community psychiatrist, MD #15, whose practice was located in another state, to notify her of Patient #7's pending inpatient psychiatric admission. Patient #7 was subsequently transferred to the locked Crisis Intervention Unit (CIU) at 8:00 PM on 1/7/07. Review of the clinical record identified that MD #15 returned the call to the ED at 8:15 PM on 1/7/07, and spoke with MD #6. Interview with MD #6 on 8/23/07 identified that he was unable to recall what information was shared with MD #15 but that MD #15 strongly recommended inpatient hospitalization for Patient #7.
   Interview with Patient #7 on 8/24/07 identified that she did not initially object to being held overnight in the main ED but that after being transferred into the IOU, she became upset. Patient #7 stated that she repeatedly expressed to staff that she was being held against her will but that no one would listen to her. Patient #7 stated that on the morning of 1/8/07, one nurse finally allowed her to call MD #15. Review of an un-timed progress note dated 1/8/07 by the attending psychiatrist, MD #13, identified that after interviewing Patient #7 and speaking with MD #15, it was identified that MD #15 had "misunderstood" the MD's earlier conversation and that MD #15 now felt comfortable with Patient #7's discharge. MD #13's un-timed progress note identified that Patient #7 had no current suicidal ideation, no auditory hallucinations and was safe for discharge. A nursing note dated 1/8/07 at 9:30 AM identified that Patient #7 was discharged with belongings. Review of the ED admission record lacked documentation that Patient #7 was notified of the providers' decision for inpatient admission on 1/7/07. Patient #7 was detained in the IOU and CIU pending the inpatient admission (based on bed availability)

EXHIBIT A

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from 12:35 PM on 1/7/07 until the time of discharge at 9:30 AM on 1/8/07, a total of nearly twenty one hours without the benefit of a Physician's Emergency Certificate (PEC) or documentation that Patient #7 was voluntarily accepting the pending admission. Review of facility policy related to holding adult patients involuntarily directed that when a patient's ability to make a rational decision is impaired and the physician believes the patient would be in serious danger if he/she leaves the hospital, the patient should not be allowed to sign out against medical advice unless cleared to do so and that Protective Services (security) may be called upon to assist medical personnel in detaining such patients. The policy described those situations as when a patient had been placed on a PEC or if the patient was legally conserved.

The following are violations of the General Statutes of Connecticut Section 46a-152 (d)(2) and/or the Regulations of Connecticut State Agencies 19-13-D3 (b) Administration (2) and/or (3) and/or (c) Medical staff (2)(C) and/or (4)(A) and/or (d) Medical record (3) and/or (e) Nursing service (1) and/or (i) General (6).

2. * Based on clinical record review, review of facility policies and procedures, staff interview and/or observation, the facility failed to ensure that a registered nurse supervised and/or evaluated the nursing care for Patients #6, 7, 11, 12, 21, 23, 44, 45, 61, 66, 70, 82, 83, 84, 85 and 87. The findings include:

a. Patient #6 was admitted to the hospital on 11/22/05, via the Emergency Department, after being found without a pulse and not breathing at home and was diagnosed with anoxic brain injury after cardiopulmonary arrest from an overdose. Patient #6's medical history included polysubstance abuse. Review of the clinical record from admission to discharge (11/22/05 to 3/21/07) failed to identify that Patient #6 had been weighed according to the plan of care, either weekly or two times a week. Patient #6's admission weight (11/22/05) was 176 pounds and was 154.8 pounds on 12/15/05 (12.2% weight loss). Interview with the Director and Associate Director of the Food and Nutritional Services Department, on 8/21/07, identified that all patients are weighed weekly and a patient that sustained a severe weight loss (greater than 10%) should be weighed at least three times a week. Interview with the Nurse Manager of 5-7, on 8/21/07, identified that weights are completed weekly, or more often, for all patients.

b. Patient #7 was transferred to the Emergency Department (ED) from home via ambulance on 1/7/07 with complaints of increased depression. A list of Patient #7's medications prior to admission was obtained. Patient #7 was evaluated by the ED physician, medically cleared, and remained in the ED with a sitter until the patient was transferred to the Intensive Observation Unit (IOU) at 6:32 AM. Review of an evaluation by MD #14 at 12:35 PM on 1/7/07 identified that based on the evaluation; the plan was to admit Patient #7 for inpatient treatment. Review of physician orders dated 1/7/07 at 12:45 PM directed the administration of the medications, Gabapentin, one hundred (100) milligrams (mg.), Levothyroxin, one hundred and twenty five (125) micrograms (mcg.), Benzapril ten (10) mg., and Hydrochlorathiazide twelve and one half (12.5) mg. with directions to administer the first dose "now." Review of the medication administration documentation identified that the medications were not administered to Patient #7 until 5:34 PM, more than four hours after the physician requested the medications be given.

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Review of the clinical record lacked documentation to reflect the rationale for the delay. Review of the facility's medication administration policy directed that most scheduled medications are given within the half hour before or after their scheduled administration time and that the nurse ensures that all oral medications are taken by the patient as prescribed. The policy lacked specific direction of expected time frames for administration of medications prescribed by a physician with a request to administer the medications "now."

Patient #7 identified that she had spoken to an on call physician on 1/6/07 because she felt she was having a reaction to her current antidepressants and that the on call physician had called an ambulance so that she could be seen in the ED. Patient #7 was triaged at 12:08 AM at a Triage level II and expressed having thoughts of suicide over the previous two to three days but that "I'm not going to do it." Patient #7 was evaluated by the ED physician, medically cleared, and remained in the ED with a sitter until the patient was transferred to the Intensive Observation Unit (IOU) at 6:32 AM. Review of the documentation from 6:32 AM to 11:00 AM identified that Patient #7 was sitting quiet and occasionally resting.

At 11:10 AM on 1/7/07, the documentation identified that Patient #7 was visited by a physician at the patient's bedside in the IOU. At 12:00 PM, twelve hours after arrival in the ED and less than one hour after the physician visit, Patient #7 became very agitated and began pacing. The documentation identified that ED Technician #1 (ED Tech #1) asked Patient #7 several times to sit back down in the chair and to move away from the doorway. ED Tech #1 identified in her note that Patient #7 was not cooperative and that she "advised" the patient that she would call Security and have the patient put in restraints. Interview with Patient #7 on 8/24/07 at 10:00 AM identified that she became even more upset when ED Tech #1 "threatened to tie me up." Patient #7 stated that ED Tech #1 did, in fact, call Security but that the situation resolved itself without further action. Interview with ED Tech #1 on 8/21/07 at 11:45 AM identified that she believed that Patient #7 was trying to elope and that she was trying to keep the patient safe. Review of the ED Tech job description identified that the ED Tech was under the direction of the clinical nurse, notifies the patient's nurse of any changes in the patient's condition, and requests assessment by the nurse. In addition, the ED Tech was responsible to adhere to the facility's hospital wide Standards for Customer Service. Review of the Customer Service document identified that hospital values and dignity are communicated through actions and choice of words. Interview with the ED Nurse Manager on 8/17/07 identified that ED Tech #1 was counseled regarding her inappropriate behavior after the 1/7/07 incident involving Patient #7.

c. Patient #11 arrived at the Emergency Department (ED) at 11:04 PM on 8/10/07 under police custody with complaints of suicide ideation. During a tour of the locked Crisis Intervention Unit (CIU) on 8/13/07 at 2:10 PM, Patient #11 was observed in two point restraints. Interview with facility staff identified that Patient #11 remained under arrest and that a member of the arresting police department was present. Interview with the ED Nurse Manager at the time of the observation identified that when a patient comes to the ED under arrest, a police officer from the arresting police department is assigned to the emergency department, makes the decisions about the level of restraint needed, and is responsible for direct observation of the patient. The ED Nurse Manager stated that the CIU staff worked with the police officer when based on their

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

assessments, the patient may be allowed a less restrictive restraint for example, to feed themselves. In addition, the ED Nurse Manager stated that the CIU staff was responsible for documentation of the usual assessments directed by policy for any patient in restraints. Review of the clinical record identified that upon arrival to the ED, Patient #11 was placed in four point restraints. Review of the restraint flow record identified that Patient #11 remained in four point restraints for the next seventeen hours until 5:10 PM on 8/11/07. The documentation identified that Patient #11 remained in two point restraints from 5:10 PM on 8/11/07 through 8/13/07 with the exception of a period of time during the evening of 8/12/07 (6:15 PM to 11:50 PM). Although review of the restraint flow sheets dated 8/10/07 through 8/13/07 identified that hourly "safety checks" were provided, the flow sheets lacked consistent documentation to reflect that Patient #11 was assessed and/or monitored (circulation, skin checks, and ROM) by the CIU staff in accordance with facility policies. Review of the facility's Restraint/Seclusion policies and the policy regarding monitoring of patients in custodial restraints both directed that monitoring and observation of patients in restraints would include assessments of skin integrity, circulation, and ROM every two hours and vital signs every four hours while awake. In addition, the policy directed that an RN assessment be provided at least every four hours. Review of the clinical record lacked documentation to reflect that the decisions related to the application of Patient #11's custodial restraints were made collaboratively with the Patient Service Manager (PSM), security, and the local law enforcement agency in accordance with facility policies.

d. Patient #12 arrived at the ED at 12:08 AM on 8/13/07 under police custody with complaints of injury due to an altercation accompanied by tonic-clonic seizure activity reported to the ED by the ambulance staff. In addition, a Police Emergency Examination Request document requested that Patient #12 be evaluated for suicidal ideation due to comments made by the patient at the time of the arrest. Review of the clinical record identified that upon arrival in the ED, Patient #12 was placed in four point restraints. During a tour of the CIU on 8/13/07 at 2:10 PM, Patient #12 was observed in two point restraints. Interview with facility staff identified that Patient #12 remained under arrest and that a member of the arresting police department was present. The documentation identified that Patient #12 remained in four point restraints through 5:30 AM on 8/13/07 at which time, the patient's restraints were reduced to two points. Review of the clinical record lacked documentation to reflect that the decisions related to the application of Patient #12's custodial restraints were made collaboratively with the PSM, security, and the local law enforcement agency in accordance with facility policies.
Review of facility policies regarding patients who require custodial restraints directed that although a physician order was not needed for the custodial restraints, that the decision to use restraints for custodial reasons would be made jointly by the Patient Service Manager (PSM) and the Department of Protective Services (the facility's security department) in collaboration with the law enforcement agency. The facility's policies directed that an assessment and management form be completed for any patient believed to require custodial restraints that included information related to threat level, risk of escape, and determination of under what circumstance the restraints could be removed.

e. Patient #21 was admitted to the hospital on 6/26/07 with a lumbar spinal fracture. Review of

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

the nursing admission assessment dated 6/26/07 identified that the patient ' s Braden score was a 12 (high risk for pressure sores) with the skin intact. Review of the nursing flowsheets dated 6/26/07 identified that the patient ' s skin under her cervical collar was intact. Further review of the nursing flowsheets dated 6/27/07-7/1/07 identified that the patients skin was not monitored every shift and per hospital policy. Review of the nursing flowsheet dated 7/2/07 identified that Patient #21 had a Stage II skin breakdown under her cervical collar. Further review failed to identify that assessment and measurements of the patient ' s skin breakdown under the cervical collar were completed. In addition, review of the nursing flowsheets dated 6/26/07 identified that the patient had a blister in the skin fold below a surgical incision dressing. On 7/3/07, the area was described as a deroofed blister to the left skin fold measuring 1.5cm X 6cm with necrotic edges. In addition, review of the progress notes and nursing flowsheets dated 6/27/07-7/20/07 identified that the patient had an unstageable pressure sore to the sacral/coccyx area. Further review failed to identify that the patient ' s wound was assessed, measured and monitored consistently. Review of the operative reports dated 7/8/07 and 7/20/07 identified that the patient's pressure sore to the sacral/coccyx area was surgically debrided. Interview and review of the clinical record with the wound care nurse on 8/14/07 identified that the patient had maceration to the sacral and buttock area due to stooling and was being treated with ilex paste to those areas, however, observation of Patient #21's wounds on 8/15/07 with the Wound Care Nurse identified that the patient had a Stage IV wound to the back area measuring 2.5cm X 12.5cm X 1.75cm, a necrotic area to the right buttock area and multiple Stage II's with macuration on the surrounding buttock and sacral area measuring 12.5cm X 10cm. At this time the physician ordered an eclipse bed.

Review of the physician orders and nursing care plan dated 6/27/07 identified that Patient #21 was to be weighed weekly. Review of the admission dietary consult dated 7/4/07 (8 days later) identified that the patients weight was 89kg (196.21 lbs) with recommendations to weigh the patient weekly. Review of the nursing flowsheets dated 6/27/07-8/15/07 identified that the patient was not weighed per physician order and per dietary recommendations.

Review of hospital policy identified that collaborative problems are conditions that the nurse and the interdisciplinary team members monitor to detect onset of/or a change in status. Further review identified that patients are to be weighed on admission and weekly on Wednesdays for patients who are high risk for pressure sores. Interview with the Director of Nursing/Medicine on 8/20/07 identified that she would have expected that the dietary recommendations were followed. Further interview identified that the beds in the intensive care units all have the capabilities of weighing patients and could not determine why the patient had not been weighed.

f. Patient #23 was admitted on 8/12/07 with an altered mental status. Review of progress notes dated 8/12/07 and 8/13/07 identified that on 8/12/07 at 10 PM the patient was out of bed and became threatening, combative and aggressive. The patient was placed in 4-point wrist and ankle restraints and at the waist. The clinical record was reviewed with the Patient Service Manager and Clinical Service Manager on 8/14/07 and noted that the record failed to identify nursing assessments of the patient's condition while restrained and lacked documentation of when the restraints were removed.

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

According to the Hospital policy for restraint use, documentation is to reflect that staff observed and monitored the patient every one hour, the patient's response, nursing assessments while restrained, and the time the restraint was released.

g. Patient #44 was admitted to the hospital on 8/8/07, via the Emergency Department with elevated creatinine and the diagnosis of acute renal failure and the treatment plan for the patient included hemodialysis. Patient #44's medical history included Wegner capillaritis, restrictive airway disease, seizures, gout, hypertension, chronic renal insufficiency and pulmonary edema. The Nursing Admission Assessment dated 8/9/07 identified that the patient was at low risk to develop a pressure ulcer and failed to identify any alterations in skin integrity. The "Adult Med/Surg Flow Sheet" dated 8/11/07 identified that Patient #44 had a skin tear on the left hand measuring 5.0 centimeters (cm) by 4.0 cm and had an area on the left heel, status post incision and drainage 2 weeks prior to admission, that measured 1.0 cm by 0.5 cm. In addition, review of the "Adult Med/Surg Flow Sheet" dated from 8/12/07 to 8/14/07 failed to identify these two alterations in skin integrity. Interview with the Nurse Manager of the 10-7 unit on 8/14/07 identified that each patient's skin is assessed and that assessment is documented daily on the flowsheet.

In addition, the physician orders dated 8/8/07 directed the staff to weigh the patient daily. Review of the "Adult Med/Surg Flow Sheet" dated from 8/8/07 to 8/14/07 failed to identify that Patient #44 was weighed daily (no weights were recorded on 8/10/07, 8/11/07, 8/12/07 and 8/13/07). Additionally the patient had a 17.8-pound weight loss from 8/9/07 to 8/14/07. Interview with the Nurse Manager of the 10-7 unit on 8/14/07 identified that Patient #44 was not weighed daily and that the patient was on a bed with a built in weight scale.

Additionally, Patient #44 received hemodialysis treatments on 8/8/07, 8/9/07, 8/10/07, 8/11/07 and 8/13/07. Review of the "Acute Hemodialysis Flowsheet" failed to identify that the patient was weighed predialysis on 8/8/07, 8/10/07 and 8/11/07. Review of the hospital policy, titled "Care of the Patient Receiving Hemodialysis" identified that the predialysis weight is required.

h. Patient #45 was admitted to the hospital on 8/11/07, via the Emergency Department, after an un-witnessed fall, was diagnosed with a right intertrochanteric fracture and had a right hip replacement on 8/12/07. Patient #45's medical history included dementia, coronary artery disease, breast cancer, hypertension and chronic renal insufficiency. The Nursing Admission Assessment, dated 8/11/07, identified that Patient #45's skin was intact and the patient was at high risk to develop a pressure ulcer. Review of the physician orders, dated 8/11/07 at 8:27 P.M. directed the staff to use an "Eclipse Mattress" (a pressure-relieving mattress). Observation on 8/14/07 identified that the patient did not have an Eclipse Mattress. Interview with the Nurse Manager of the 7-7 unit, on 8/14/07, identified that there is no information that the physician was informed that the Eclipse Mattress was not used for Patient #45. Additionally, interview with RN #6, on 8/14/07, identified that Patient #45 had a pressure ulcer on the coccyx, stage one measuring 2.0 centimeters (cm) by 2.0 cm and the skin was red in color. Interview with MD #10, on 8/14/07, identified that she was not aware that Patient #45 had a pressure ulcer on the coccyx.

i. Patient #61 was admitted to the hospital on 7-1-07, via the Emergency Department, after being found unresponsive and not breathing. Patient #61's medical history included chronic

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obstructive pulmonary disease, polysubstance abuse, psychosis, attention deficit disorder, narcolepsy and hypertension. The Nursing Admission Assessment dated 7/1/07 identified that Patient #61's skin was intact and the patient was at high risk to develop a pressure ulcer. The "Adult Critical Care Flowsheet" dated 7/5/07 identified that Patient #61 had an ecchymotic area on the back of the head measuring 5.5 centimeters (cm) by 3.0 cm which developed into a stage 2 pressure ulcer on the back of the head measuring 2.0 cm by 2.0 cm on 7/11/07. The medical record failed to identify the wound measurements including the color of the ulcer bed, the presence of exudates, odor, pain and/or erythema and evaluation of the surrounding skin as per policy. Observation of care on 8/15/07 from 10:15 A.M. to 11:00 A.M. provided by PCA #4 and RN #4 identified that at 10:15 A.M., Patient #61 was in bed, on an ACCU MAX mattress (a pressure relieving mattress) lying on his back with his head on one pillow-which did not relieve the pressure on the patient's head ulcer. In addition, RN #4 removed the dressing from the back of the patient's head, measured the area (approximately 3 cm by 3 cm) and reapplied the "Allevyn Thin" dressing. Interview with the Nurse Manager of the Medical Intensive Care Unit, on 8/15/07, identified that the staff utilized interventions for Patient #61 to prevent skin breakdown including daily skin assessments, repositioning side to side every two hours and application of a protective ointment to all bony prominences. Review of the hospital policy titled "Pressure Ulcer: Prevention and Treatment" identified that the staff should avoid positioning the patient on an ulcer and documentation of the skin breakdown area includes location, stage, size, color of ulcer bed, the presence of exudates, odor, pain and/or erythema and evaluation of the surrounding skin.

j. Patient #66 had a medical history of heart failure, cardiomyopathy and acute tubular necrosis and required hemodialysis. Review of the patient's Acute Hemodialysis Flowsheet dated 8/9/07 with the Director of the Inpatient Hemodialysis Unit, identified that the patient had experienced chest pain at a level of 8 to 9 on a scale of 1-10 (1 being the least and 10 being the most) during a dialysis treatment. Review of medication documentation identified that the patient was medicated with Morphine 10 mg by mouth at 7:10AM and at 10:30 AM. The nursing narratives failed to be timed or reflective of the effect of the pain medication.

k. Patient #70 was admitted to the facility on 8/13/07 with chest pain. Review of the clinical record identified that Patient #70 had a history of substance abuse and reported thoughts of suicidal ideation on admission. Patient #70 was admitted to the medical unit for diagnostic testing to rule out a Myocardial Infarction (MI). Review of the care plan dated 8/13/07 identified Patient #70's suicidal ideation and risk of elopement with interventions that included the need for a constant observer/sitter. During a tour of the 9-5 medical nursing unit on 8/16/07 at 10:15 AM, a staff member, later identified as a constant companion/sitter for Patient #70, was observed to be sitting in a chair at the doorway of the patient's room, out of direct visual contact with the patient, by a surveyor of the Building, Fire, and Safety Investigation Unit (BFSI). Upon inquiry, the BFSI surveyor was told that the patient, Patient #70, required the constant companion due to concerns related to the patient's psychiatric diagnosis. At 2:15 PM on 8/16/07, the constant companion assigned to Patient #70 was again observed in the doorway of the patient's room. Various types of medical equipment including loops of suction tubing remained in the patient's room. Based on the constant companion's location, although the

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companion may have had limited view of the mattress area at the footboard of the patient's bed, the companion was unable to maintain direct visual contact with the patient who was lying in a bed with the bathroom wall obstructing her view. Interview with Constant Companion #1 at the time of the observation identified that she usually sat in the recliner chair in the doorway of the room, believed that she would be able to tell if the patient was going to get out of bed, but that she did not have full view of the patient from her position in the doorway. Review of the facility's policy related to the role and responsibilities of a constant companion identified that the constant companion supports the primary nurse in maintain a safe environment for patient including those who have a potential for harming themselves. The policy directed that the constant companion remain in visual contact with the patient at all times, accompanying the patient everywhere and to never leave the patient alone, even in the presence of a family member.

l. Patient #82 was admitted to the hospital with an intraparenchymal hemorrhage. Review of the physician's orders dated 8/13/07 identified that the patient was to have neurological checks completed with each vital sign check. Review of the care plan dated 8/13/07 identified that the patient was to have neurological checks every four hours and that the physician was to be notified with any changes. Review of the nursing flowsheets dated 8/13-8/14/07 identified that even though a neurological check was done once that shift, it was not completed per unit standards which included a complete glascow coma score and an assessment completed every four hours. Interview with the Nurse Manager of 6-3 on 8/14/07 identified that the expectation was for neurological checks to be completed every four hours.

m. Patient #83 was admitted on 5/6/07 after a motor vehicle accident. Patient #83 sustained a traumatic brain injury and multiple fractures including a left tibia/fibia fracture. Review of the admission nursing documentation identified that the patient's skin was intact and the braden score was 9 (very high risk for pressure sores). Review of the nursing care plan identified that the left foot was to be checked every shift for color, motion and sensation due to an external fixator boot that was on the patient. Review of the progress notes and nursing flowsheets dated 5/6/07 to 8/20/07 identified that Patient #83's skin was inconsistently monitored for breakdown and per hospital policy. On 6/8/07, the patient was identified to have a Stage I reddened area without breakdown to the right upper buttock/hip. On 7/17/07, a Stage II pressure area of the lateral and medial ankle was noted. On 7/18/07 a pressure area of the left outer ankle measuring 2cm X 2cm, unstageable, was noted; a left inner ankle pressure sore, 1.5cm X 1.5cm, unstagable, was identified; a right buttock 1cm X 1.5cm unstagable area was noted; and a Stage I to coccyx was noted. Review of the wound consultant noted dated 8/6/07 identified that the patient had a Stage II to the sacral/coccyx area, 0.5cmm, and a Stage II to the left buttock, 1.5cm X 2cm. Also identified was an area on the left lateral ankle, 1.5cm X 2cm, with yellow slough and an area on the left medial ankle, 0.5cm X 1.5cm, with separating eschar. Recommendations on 8/6/07 indicated that an eclipse surface bed was needed. Review of the physician progress notes indicated that the eclipse bed was not ordered until 8/8/07. Review of hospital policy identified that if a pressure sore develops in the hospital, documentation is required in the plan of care, progress notes and flowsheets. In addition, the wound should be assessed daily and measured on admission, weekly and within 24 hours of discharge. Further review identified

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that a low-air loss or air-fluidized bed is needed when a patients braden score is less than or equal to 12, when stage II sites occur on multiple turning surfaces, when Stage III or Stage IV sites occur, or if a patient cannot tolerate turning or having the head of bed lowered. Review of dietary consult for Patient #83 dated 5/8/07 identified that the patient's weight on admission was 154.33lbs (70kg) and that the patient was at high risk for protein and calorie malnutrition. Recommendations included to weigh the patient weekly and, when the patient was off Propofol, to start tube feedings at 90ml/hr (goal). On 5/16/07, the dietary consult indicated that the patient was not weighed. On 5/31/07, the patients weight was 143lbs (65.1kg) and the accuracy of the ICU bedscale weights were questioned. Instructions were to continue to monitor closely and to complete weekly weights. The dietary consult dated 6/12/07 indicated that the patient's weight was 137 lbs (62.4kg) and recommended that the patient be weighed three times a week. Review of the nursing flowsheets dated 6/12/07 to 8/20/07 failed to identify that the patient had been weighed three times per week. Review of the dietary consults dated 7/13/07 to 8/13/07 identified that the patient had not been weighed since 7/13/07, at which time his weight was noted to be 109.12lbs (49.6kg). Subsequently to surveyor inquiry, Patient #83 was weighed on 8/21/07 with a weight of 114.7lbs (40lb weight loss).

n. Patient #84 was admitted to the hospital on 5/13/07 after a motor vehicle accident. Patient #84 had sustained multiple injuries including T1 and T3 fractures. Review of the nursing admission assessment dated 5/13/07 identified that the patient's braden scale score was 10 (high risk for pressure ulcers). On 5/13/07, Patient #84 had a cervical collar applied. Review of the interdisciplinary care plan dated 5/14/07 identified that the patient's skin was to be assessed every shift. Review of the nursing flowsheets dated 5/13-6/15/07 failed to reflect that the patient's skin integrity was assessed; pads changed and failed to reflect when the collar was removed and reapplied. Subsequently, on 5/25/07 Patient #84 developed a Stage II pressure sore located under the left side of the chin under the collar. Further review failed to identify that measurements of the Stage II on the left chin were completed. Review of the nursing flowsheets dated 5/28/07 identified that the patient had a Stage IV pressure area to the left side of chin measuring 3.5cm x1.5cm x 1/2cm with yellowish drainage, a foul odor, and redness to surrounding area. Review of the nursing flowsheets dated 5/29/07 identified that the Stage IV wound to the left chin had green and beige drainage. Further review of the nursing flowsheets dated 5/28/07 to 6/15/07 failed to identify consistent skin assessments. On 5/29/07 at 10:00 AM, the cervical brace was repositioned and then removed at 6:00pm by MD #16. Interview with MD #16 on 8/20/07 identified that he had removed Patient #84's brace on 5/29/07 and the brace was not reapplied. Review of hospital policy identified that for c-spine immobilization, skin integrity involves removing the collar to assess skin integrity twice a day and document the findings. Further review of hospital policy identified that if a pressure sore develops in the hospital, documentation is required in the plan of care, progress notes and flowsheets. The policy directs daily assessment and measurement of the wound on admission, weekly and within 24 hours of discharge.

Review of the dietary consults for Patient #84 dated 5/17/07 identified that the patient had an estimated weight of 192lbs (87kg) and had been NPO for 4 days. Dietary recommendations included to start tube feedings with a goal of 115cc per hour and to obtain a weight now and

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weekly. Review of the dietary consult dated 5/30/07 identified that the patient ' s weight was 132lbs (60kg) and questioned the accuracy of the bed weight. Dietary recommendations included to weigh the patient three times per week (zero scale when able). Review of the nursing flowsheets dated 5/17/07-6/13/07 failed to identify that the patient was weighed per dietary recommendations. Patient #84 was discharged on 6/13/07. Review of the admission data from the rehabilitation facility dated 6/14/07 identified that the patient's weight on admission was 152lbs. (40 lb weight loss in 31 days). Review of hospital policy identified that collaborative problems are conditions that the nurse and the interdisciplinary team members monitor to detect onset of/or a change in status. Further review identified that patients are to be weighed on admission and weekly on Wednesdays for patients who are high risk for pressure sores. Interview with the Nursing Director of Medicine on 8/20/07 identified that she would have expected dietary recommendations to be followed in regard to monitoring the patient's weight. Further interview identified that the beds in the intensive care units all have the capability of weighing patients.

o. Patient #85 was admitted to the hospital on 3/31/07 with sepsis and pneumonia. Patient #85 had a history of bilateral below the knee amputations, NIDDM and PVD. Review of the admission nursing assessment dated 3/31/07 identified that the patient's skin was intact and the Braden score was 11 (high risk for pressure sores). On 4/2/07, Patient #85 was placed on a Rite Hite bed. Review of the nurses' notes dated 4/2/07 identified that the patient had a Stage II to the sacrum area and that the patient was not happy with the Rite Hite bed. Patient #85 was then placed on a regular bed with an accumax pump. Review of the initial wound care consult on 4/13/07 identified that on 4/7/07 the sacral ulcer was noted to be unstageable measuring 10cm X 12cm with a 2cm band of ecchymotic/black tissue and a Stage II measuring 2cm on left buttock. Recommendations included Eclipse mattress with scale bed because the patient was on dialysis and the need for weights and dietician input secondary to healing needs. Review of the physicians orders dated 4/13/07 identified that the Eclipse bed was ordered. Review of the nursing flowsheets dated 4/1/07-8/15/07 failed to identify that the patient ' s wound was assessed daily and measured weekly per hospital policy. Further review identified that the initial wound consult was not completed until 6 days after the patient had developed an unstageable pressure sore. On 5/2/07, the patient ' s sacral wound was measured as 7cm X 11.5cm without depth, with a black/yellow/red base, and the site was debrided by the physician assistant. Review of the progress notes dated 6/7/07 identified that the patient had a new undermined site with Stage IV pressure sacral ulcer measuring 11cm X 5cm X 2 cm with the base 50 % yellow/black and 50 % red with yellow fibrous material. Review of the nursing flowsheets dated 8/15/07 identified that the patient had a healing Stage IV measuring 5cm X 2.5cm and a Stage I to the left hip. Review of hospital policy identified that if a pressure sore develops in the hospital, documentation is required in the plan of care, progress notes and flow sheets. In addition, staff should assess daily and measure the wound on admission, weekly and within 24 hours of discharge. Further review identified that a low-air loss or air-fluidized bed is needed when a patients Braden score is less than or equal to 12, Stage II sites on multiple turning surfaces, Stage III or Stage IV sites, and if a patient cannot tolerate turning or having the head of bed lowered.

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Patient #85 was receiving dialysis and was identified as high risk for pressure sores. Review of the admission dietary consult dated 4/4/07 identified that the patients weight was 71.7kg (158.07lbs) with recommendations to weigh the patient weekly. Review of the nursing flowsheets dated 7/4/07 identified that the patient's weight was 64.5kg (142lbs.). Further review of the nursing flowsheets dated 7/5/07-8/14/07 identified that the patient was not weighed per physician order and per dietary recommendations. Patient #85's weight on 8/15/07 was 53.6kg (118lbs) (40 lb weigh loss since admission). Review of hospital policy identified that patients are to be weighed on admission and weekly on Wednesdays for patients who are high risk for pressure sores. Interview with the Director Nursing/Medicine on 8/20/07 identified that she would have expected that the dietary recommendations were followed if the patient needed to be weighed. Further interview identified that the beds in the intensive care units all have the capability of weighing patients and could not determine why the patient had not been weighed.

Review of the dialysis treatment records for Patient #85 dated 4/07-8/07 failed to identify that the patient was weighed pre/post dialysis treatments. In addition, review of the progress notes dated 4/3/07 identified that Patient #85 came back from dialysis with difficulty breathing, clammy, pale skin with a pulse oximetry level of 90%. Patient #85 was sent to the ICU for treatment of hyponatremia and pneunomia. Review of hospital policy identified that pre/post weighs are to be completed when a patient is receiving dialysis treatments.

p. Patient #87 was admitted to the facility on 8/15/07. Review of the patient's admission history and physical identified that Patient #87 had a history of asthma. Review of the physician's order dated 8/15/07 directed the administration of an Albuterol (Proventil) inhaler two puffs twice daily. Observation of a medication pass on 8/15/07 at 10:45 AM identified that RN #3 handed Patient #87 the Albuterol inhaler without the benefit of shaking the inhaler or instructing the patient on its use. Patient #87 appeared slow to respond, failed to shake the inhaler prior to use, and was observed to place the mouthpiece of the inhaler loosely to the lips as she self-administered four puffs from the inhaler. Subsequent to Patient #87's inhaler use, RN #3 requested Patient #87 to "take a couple of deep breaths" and at that time reminded the patient to only take two puffs. Review of the Albuterol inhaler administration instructions directed that prior to use, the Albuterol inhaler should be shaken well, that mouthpiece should be well into the mouth and to inhale deeply as the dose of medication from the inhaler is released. While a substitute method included holding the mouthpiece "two fingers width" away from the mouth, the instruction to inhale deeply as the dose from the inhaler was released was constant in both methods. Review of facility policy directed that the nurse is responsible for knowing the usual dosage, range, and route of administration as well as how to use and access necessary equipment prior to administration of a medication.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 Section (b) Administration (2) and/or (d) Medical records (3) and/or (e) Nursing service (1) and/or (i) General (6).

3. * Based on clinical record review, review of facility policies and procedures and staff interviews the

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facility failed to ensure that nursing staff developed and/or maintained a current nursing care plan for Patients # 21, 23, 37, 65, 69, 71, 83 and 84. The findings include:

a. Patient #21 was admitted to the hospital on 6/26/07 with a lumbar spinal fracture. Review of the nursing admission assessment dated 6/26/07 identified that the patient's Braden score was a 12 (high risk for pressure sores) with the skin intact. Review of the nursing flowsheets dated 6/26/07 identified that the patient's skin under her cervical collar was intact. Review of the nursing flowsheet dated 7/2/07 identified that Patient #21 had a Stage II skin breakdown under her cervical collar. Review of the nursing flowsheets dated 6/26/07 identified that the patient had a blister in the skin fold below a surgical incision dressing. On 7/3/07, the area was described as a deroofed blister to the left skin fold measuring 1.5cm X 6cm with necrotic edges. In addition, review of the progress notes and nursing flowsheets dated 6/27/07-7/20/07 identified that the patient had an unstageable pressure sore to the sacral/coccyx area. Review of the operative reports dated 7/8/07 and 7/20/07 identified that the patient's pressure sore to the sacral/coccyx area was surgically debrided. Review of the nursing care plan dated 7/10/07 identified that the patient had a debrided wound to the skin fold measuring 12cm X 5cm X 4cm however, the nursing care plan failed to reflect the patient's ongoing, current status and treatments to her wounds and/or additional wounds presently noted. Interview and review of the clinical record with the wound care nurse on 8/14/07 identified that the patient had maceration to the sacral and buttock area due to stooling and was being treated with ilex paste to those areas, however, observation of Patient #21's wounds on 8/15/07 with the Wound Care Nurse identified that the patient had a Stage IV wound to the back area measuring 2.5cm X 12.5cm X 1.75cm, a necrotic area to the right buttock area and multiple Stage II's with macuration on the surrounding buttock and sacral area measuring 12.5cm X 10cm. At this time the physician ordered an eclipse bed.
In addition, review of hospital policy identified that collaborative problems are conditions that the nurse and the interdisciplinary team members monitor to detect onset of/or a change in status. The Interdisciplinary Plan of Care Policy states that interventions to meet treatment goals and objectives should be identified. Further review identified that patients are to be weighed on admission and weekly on Wednesdays for patients who are high risk for pressure sores. In addition, review of hospital policy identified that if a pressure sore develops in the hospital, document is required in the plan of care, progress notes and flowsheets.

b. Patient #23 was admitted on 8/12/07 with an altered mental status. Review of progress notes dated 8/12/07 and 8/13/07 identified that on 8/12/07 at 10 PM the patient was out of bed and became threatening, combative and aggressive. The patient was placed in 4-point wrist and ankle restraints and also restrained at the waist. The clinical record was reviewed with the Patient Service Manager and Clinical Service Manager on 8/14/07 and noted that the care plan did not reflect the patient's behaviors and did not include the patient's need for restraints.

c. Patient #37 was admitted to the Well Baby Nursery on 8/9/07. The progress note dated 8/10/07 at 3:35 PM by the Pedi-ortho attending identified that two-clubfoot casts had been applied. The nursing note dated 8/11/07 on the 11-7 shift identified that the bilateral cast was in place with positive CMS (circulation, motion, sensory) to bilateral extremities. The nursing note on 8/14/07 at 5 AM identified an open area behind the right knee with scant drainage and identified

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that the cast did not seem to be at that site. The Attending note on 8/14/07 at 8 AM identified a pressure sore on the right lower extremity in the popliteal area. The nursing note on 8/14/07 on the 7-3 PM shift identified the area as a 1/8-inch abrasion to the right popliteal area with no drainage and that the MD had been aware, bacitracin applied and stockinette applied to the edge of the cast to avoid further abrasion. The nursing note at on 8/14/07 at 7 PM identified the area as a Stage 2 ulcer on the right lower extremity popliteal area related to friction/pressure from the cast. The note identified the area was approximately ¼ inch in length and 1/8 inch in width with mild erythema and that the area had been cleansed with sterile water and that bacitracin was applied followed by tegasorb.

Review of the daily assessment sheets from the period of 8/10/07 through 8/13/07 identified that integumentary assessments were within normal limits.

Review of the Plan of Care dated 8/14/07 identified that a cast had been applied on 8/10/07 with nursing interventions dated 8/14/07 to assess bilateral extremities as per policy.

Review of the facility policy on Skin Care of the High Risk Patient identified that the Plan of Care should contain individualized needs for the infant and referenced the facility's clinical practice skin/wound reference guide. Review of the facility's clinical practice on pressure ulcer prevention and treatment identified patients with pre-disposing factor that included a cast, are at risk for the development of pressure ulcers. It identified that a Stage 2 ulcer is superficial and presents clinically as an abrasion, blister or shallow crater. This policy directed that a Braden Pressure Ulcer Risk Assessment would be used, and identified score risks for pediatric with ages less than 18 years of age.

Interview and review of the record on 8/15/07 at 10 AM with the Clinical Manager RN #8 identified that the Plan of Care identified that the patient was casted on 8/10/07 and lacked identifying specific comprehensive interventions for the monitoring of the cast.

d. Patient #65 was admitted on 7/12/07 for cancer treatment. Review of the clinical record identified the patient restrained with bilateral wrist restraints from 8/10/07 to 8/15/07 due to interfering with medical lines. The clinical record and care plan were reviewed with the Patient Service Manager and Clinical Service Manager on 8/15/07 and noted that the care plan did not reflect the patient's behaviors and did not include the patient's need for restraints.

According to the Hospital policy for restraint use, staff were to develop a plan to correct the behavior necessitating the restraint.

e. Patient #69 was admitted to the facility following an overdose of several types of medications. Review of the Physician Emergency Certificate (PEC) dated 8/14/07 identified that Patient #69 had a history of multiple psychiatric hospitalizations and multiple suicide attempts. During tours of the 9-5 medical nursing unit on 8/15/07 at 10:30 AM and 2:00 PM, a constant observer/sitter was observed to be sitting in Patient #69 ' s room. Review of the care plan dated 8/15/07 failed to reflect the problem and/or rationale for the constant companion/sitter. Subsequent to surveyor inquiry, the care plan was revised to include staff concerns related to the patient ' s violent behavior and risk to harm self with interventions that included removal of all dangerous objects and assignment of a staff person for constant visual contact with the patient while on the medical unit.

f. Patient #71 was admitted to the facility on 4/6/07 with diagnoses that included a depressive

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disorder and Wernicke's encephalopathy. Interview with Care Coordinator #1 on 8/15/07 at 2:50 PM identified that Patient #71 required twenty four hour a day care but that the facility was having difficulty placing the patient in an extended care facility due to lack of payment source. Review of the clinical record identified that Patient #71 had recently eloped twice from the facility and was at risk for further elopement. Review of the plan of care dated 5/3/07 identified that Patient #71 was at risk for elopement but lacked revisions to the care plan when the patient successfully eloped twice in a four day period and/or interventions that included a constant companion/sitter.

Review of facility policies identified that an interdisciplinary plan of care would be formulated to assure that patients receive coordinated care and treatment. The elements of the care plan would be problem statement, outcomes of care, and prescribed interventions used by the interdisciplinary team to meet the individualized needs of the patient. In addition, the policy directed that patient response to treatment, goals, and interventions would be reevaluated and revised as clinically significant.

g. Patient #83 was admitted on 5/6/07 after a motor vehicle accident. Patient #83 sustained a traumatic brain injury and multiple fractures including a left tibia/fibia fracture. Review of the admission nursing documentation identified that the patient's skin was intact and the Braden score was 9 (very high risk for pressure sores). Review of the nursing care plan identified that the left foot was to be checked every shift for color, motion and sensation due to an eternal fixator boot in place. Further review failed to identify that the care plan was revised including interventions when the patient developed pressure sores. In addition, upon surveyor inquiry on 8/15/07, the care plan was updated to reflect the patients pressure areas but lacked a revised care plan for the Stage II to the coccyx area. Review of the progress notes and nursing flowsheets dated 5/6/07-8/20/07 identified that Patient #83's skin was inconsistently monitored including assessments and/or interventions for prevention. On 6/8/07, the patient was identified to have a Stage I reddened area without breakdown to the right upper buttock/hip. On 7/17/07 a Stage II lateral and medial ankle was noted, on 7/18/07 the left outer ankle 2cm X 2cm unstageable, left inner ankle 1.5cm X 1.5cm unstagable area, right buttocks 1cm X 1.5cm unstagable area, Stage I to coccyx. On 7/19/07, the eternal fixator boot was removed. Review of the wound consultant noted dated 8/6/07 identified that the patient had a Stage II to the sacral/coccyx area, 0.5cm, and a Stage II to the left buttock, 1.5cm X 2cm. Pressure areas were also identified to the left lateral ankle, 1.5cm X 2cm, with yellow slough and the left medial ankle, 0.5cm X1.5cm, with separating eschar. Recommendations on 8/6/07 indicated that an eclipse surface bed was needed. Review of the progress notes dated 8/8/07 indicated that the eclipse bed was ordered, and was admitted to the hospital on 6/26/07 with a lumbar spinal fracture. Review of the nursing admission assessment dated 6/26/07 identified that the patient's Braden score was a 12 (high risk for pressure sores) with the skin intact. Review of the nursing flowsheets dated 6/26/07 identified that the patient's skin under her cervical collar was intact. Further review of the nursing flowsheets dated 6/27/07-7/1/07 identified that the patient's skin was not monitored consistently. Review of the nursing flowsheet dated 7/2/07 identified that Patient #21 had a Stage II skin breakdown under her cervical collar. Further review failed to identify that assessments and measurements of the patient's skin breakdown under the cervical collar were

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completed. In addition, review of the nursing flowsheets dated 6/26/07 identified that the patient had a blister in the skin fold below a surgical incision dressing. On 7/3/07, the area was described as a deroofed blister to the left skin fold measuring 1.5cm X 6cm with necrotic edges. In addition, review of the progress notes and nursing flowsheets dated 6/27/07-7/20/07 identified that the patient had an unstageable pressure sore to the sacral/coccyx area. Review of the operative reports dated 7/8/07 and 7/20/07 identified that the patient had a pressure sore to the sacral/coccyx area that was surgically debrided. Review of the nursing care plan dated 7/10/07 identified that the patient had a debrided wound measuring 12cm X 5cm X 4cm however, the nursing care plan failed to reflect the patients ongoing and current status with her wounds. Interview and review of the clinical record with the wound care nurse on 8/14/07 identified that the patient had maceration to the sacral and buttock area due to stooling and was being treated with ilex paste to those areas, however, observation of Patient #21 ' s wounds on 8/15/07 with the Wound Care Nurse identified that the patient had a Stage IV wound to the back area measuring 2.5cm X 12.5cm X 1.75cm, a necrotic area to the right buttock area and multiple Stage II ' s with macuration on the surrounding buttock and sacral area measuring 12.5cm X 10cm.

h. Patient #84 was admitted to the hospital on 5/13/07 after a motor vehicle accident. Patient #84 had sustained multiple injuries including T1 and T3 fractures. Review of the dietary consults dated 5/17/07 identified that the patient had an estimated weight of 192lbs (87kg) and had been NPO for 4 days. Dietary recommendations included to start tube feedings with a goal of 115cc per hour and to obtain the patient's weight now and weekly. Review of the dietary consult dated 5/30/07 identified that the patient 's weight was 132lbs (60kg) and questioned the accuracy of the bed weight. Dietary recommendations included to weigh the patient three times per week (zero scale when able). Review of the interdisciplinary plan of care dated 5/23/07 identified that although the patient was receiving tube feedings, the care plan failed to reflect that the patient needed to be weighed and/or had a weight loss per dietary recommendations. Review of the nursing flowsheets dated 5/17/07-6/13/07 failed to identify that the patient was weighed per dietary recommendations. Patient #84 was discharged on 6/13/07. Review of the admission data from the rehabilitation facility dated 6/14/07 identified that the patients weight on admission was 152lbs. (40 lb weight loss in 31 days). Interview with the Nursing Director of Medicine on 8/20/07 identified that she would have expected that dietary recommendations were followed. Further interview identified that the beds in the intensive care units all have the capability of weighing patients and if the patient had a weight loss, the care plan should reflect such.

4. Based on review of the medical record and staff interview, the facility failed to ensure that Patient #66 received heparin throughout the hemodialysis treatment as ordered by the physician. The findings include:

a. Patient #66 received hemodialysis treatments on 8/9/07, 8/11/07 and 8/13/07. Review of the physician orders dated 8/9/07, 8/10/07 and 8/13/07, respectively, directed a loading dose of heparin 1000 units and a maintenance (hourly) dose of 500mg to be given during the dialysis treatment. Review of the Acute Hemodialysis Flowsheets with the Director of the Inpatient

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Hemodialysis Unit on 8/15/07, identified that although the patient received 1000 units of heparin intravenously at the start of treatment, documentation failed to identify that the patient received 500 units every hour during treatment as directed in the physician order and/or that the physician was notified of any reason to hold the heparin. During interview on 8/27/07 at 9:30 AM, the Facility Administrator stated that the patient's bleeding time was off on each of the treatment days and a decision was made to hold the heparin. However, documentation failed to identify that the physician was notified of the patient's bleeding time or the holding of the heparin.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical staff (2)(B) and/or (d) Medical records (3) and/or (e) Nursing services (1) and/or (i) General (6).

5. Based on clinical record review and interview with facility personnel for one patient (Patient #22), the facility failed to ensure that a physicians order was obtained prior to administering medications. The findings include:

a. Patient #22 was admitted to the hospital on 8/8/07 with a Retroperitoneal Bleed. Review of the nursing flowsheets dated 8/9/07 to 8/10/07 identified that Levophed 12.6mcg intravenous was started at 5:00pm and continued until 8:00am on 8/10/07. Review of the physician's orders failed to identify that an order was obtained prior to administering the medication. Review of hospital policy identified that a physicians order is needed prior to administering medications. Interview with the Nursing Director of Surgical Services on 8/13/07 identified that a physicians order should have been obtained prior to the administration of the medication.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (d) Medical records (3) and/or (e) Nursing services (1) and/or (f) Diagnostic and therapeutic facilities and/or (i) General (6).

6. Based on review of Patient #45's clinical record, staff interviews and review of facility policy, the facility failed to ensure that blood and/or blood product infusions were completed according to facility policy and procedure. The findings include:

a. Patient #45 was admitted to the hospital on 8/11/07, via the Emergency Department, after an unwitnessed fall, was diagnosed with a right intertrochanteric fracture and had a right hip replacement on 8/12/07. Patient #45's medical history included dementia, coronary artery disease, breast cancer, hypertension and chronic renal insufficiency. Review of the clinical record identified that Patient #45 received three units of leukoreduced red blood cells on 8/12/07 and 8/13/07. Review of the transfusion records failed to identify the start date, the stop date and/or the volume given. Review of the "Adult Med/Surg Flow Sheet" for 8/12/07 and 8/13/07 failed to identify the volume of the identified three units of leukoreduced red blood cells administered. Interview with the Nurse Manager of the 7-7 unit on 8/14/07 identified that the transfusion documentation lacked the dated started and/or stopped and/or the volume administered. Interview with the Blood Bank Director, MD #9, on 8/14/07 identified that the

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transfusion document should have the start date, stop date and the volume infused, although the volume is variable. Review of the hospital policy, titled "Blood/Blood Components" identified that documentation of the transfusion includes the volume infused.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (d) Medical records (3) and/or (e) Nursing services (1) and/or (h) Dietary service (1) and/or (i) General (6).

7. * Based on clinical record reviews, staff interviews and review of hospital policy for four patient reviewed that required nutritional support (e.g. Patients #6, 83, 84, and 85), the hospital failed to provide the necessary nutritional support to prevent significant weight loss. The findings include:

a. Patient #6 was admitted to the hospital on 11/22/05, via the Emergency Department, after being found without a pulse and not breathing at home and was diagnosed with anoxic brain injury after cardiopulmonary arrest from an overdose. Patient #6's medical history included polysubstance abuse. The Emergency Room documentation identified that the patient was six feet two inches tall and the "Adult Critical Care Sheet" dated 11/22/05, identified that the patient weighed 80 kilograms (or 176.0 pounds). The clinical documentation identified that the patient received parenteral (intravenous fluids) then enteral feedings, and the patient weighed 154.8 pounds (21.2 pounds or 12.2 % less) on 12/15/05. The first nutritional consult, titled "Nutrition Follow Up" was completed on 12/28/05 (one month and 6 days after admission), identified that the patient's nutritional needs were not being met on the present nutritional regime and the nutritional regime was revised. Interview with the Director and Associate Director of the Food and Nutritional Services Department on 8/21/07 identified that the first nutritional consult was completed on 12/28/05 which did not adhere to the facility policy and that Patient #6 sustained a severe weight loss (greater than 10%). Review of the hospital policy, titled "Nutritional Classification and Assessment Overview" identified that a patient who requires either enteral and/or parenteral (intravenous) nutrition is a class 4, the "Nutritional intervention is mandatory" and the initial consult is to be completed in two days. In addition, the first "Nutrition Follow Up" dated 12/28/05 identified that Patient #6 had the unique nutritional requirements "based on agitation and storming multiple times daily". Review of the clinical record failed to identify that the Dietician educated the patient and/or the patient's family of patient's unique nutritional needs and/or how the "storming" affects the patient's metabolism and weight. Interview with the Director and Associate Director of the Food and Nutritional Services Department on 8/21/07 identified that the storming that Patient #6 experienced caused a hypermetabolic state which increased the patient's nutritional needs and the dietician did not educate the patient and/or family regarding the patient's nutritional needs. Review of the hospital policy titled "Nutritional Classification and Assessment Overview" identified that the nutritional department is responsible to provide nutrition education.

b. Patient #83 was admitted on 5/6/07 after a motor vehicle accident. Patient #83 sustained a traumatic brain injury and multiple fractures including a left tibia/fibia fracture. Review of the dietary consult dated 5/8/07 identified that the patient's weight on admission was 154.33lbs

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(70kg) and that the patient was high risk for protein-calorie malnutrition. Recommendations included to weigh the patient weekly and when the patient was off Propofol to start tube feedings at 90ml/hr (goal). On 5/16/07, the dietary consult indicated that the patient had not been weighed. On 5/31/07, the patient's weight was 143lbs (65.1kg) and the accuracy of the ICU bedscale was questioned. Recommendations included to continue to monitor closely and weekly weights. The dietary consult dated 6/12/07 indicated that the patient's weight was 137 lbs (62.4kg) and recommended that the patient be weighed three times a week. Review of the nursing flowsheets dated 6/12/07 to 8/20/07 failed to identify that the patient had been weighed weekly. Review of the dietary consults dated 7/13/07 to 8/13/07 failed to identify that the patient had been weighed since 7/13/07 at which time the patient's weight was 109.12lbs (49.6kg). Further review failed to reflect that the dietician failed to assess and monitor the patient's weight and nutritional status in order to prevent weight loss. Subsequent to surveyor inquiry, Patient #83 was weighed on 8/21/07 and was identified as having a weight of 114.7lbs (40lb weight loss). Interview with the Assistant Director of Dietary on 8/20/07 identified that an assessment of weight is to be included in the dietary evaluation.

c. Patient # 84 was admitted to the hospital on 5/13/07 after a motor vehicle accident. Patient #84 had sustained multiple injuries including T1 and T3 fractures. Review of the dietary consults dated 5/17/07 identified that the patient had an estimated weight of 192lbs (87kg) and had been NPO for 4 days. Dietary recommendations included to start tube feedings with a goal of 115cc per hour and obtain weight now and weekly. Review of the dietary consult dated 5/30/07 identified that the patient 's weight was 132lbs (60kg) and the accuracy of the bed weight was questioned. Dietary recommendations included to weigh the patient three times per week (zero scale when able). Further review failed to identify that the dietary department had evaluated the patient's status prior to discharge. Review of the nursing flowsheets dated 5/17/07 to 6/13/07 failed to identify that the patient was weighed per dietary recommendations. Patient #84 was discharged on 6/13/07. Review of the admission data from the rehabilitation facility dated 6/14/07 identified that the patient's weight on admission was 152lbs. (40 lb weight loss in 31 days). Interview with Dietician #1 identified that although a dietician had seen Patient #84 and started a calorie count, the documentation failed to identify that a dietary consult was completed since 5/30/07.

d. Patient #85 was admitted to the hospital on 3/31/07 with sepsis and pneumonia. Patient # 85 had a history of bilateral below the knee amputations, NIDDM, PVD and the patient was receiving dialysis. Review of the admission dietary consult dated 4/4/07 identified that the patients weight was 158.07lbs (71.7kg). Recommendations were to weigh the patient weekly and provide tube feedings of Promote ¾ strength with 8 scoops of Beneprotein to meet goal rate of 55 cc per hour. Review of the nursing flowsheets dated 7/4/07 identified that the patient was first weighed at 141.90 lbs (64.5kg). Review of dietary consults dated 4/4/07-7/5/07 failed to identify that the patient had been weighed since admission on 3/31/07. Interview with the Assistant Director of Dietary on 8/20/07 identified that an assessment of weight is to be included in the dietary evaluation.

Review of hospital policy identified that collaborative problems are conditions that the nurse and the interdisciplinary team members monitor to detect onset or a change in status. Further

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review of hospital policy identified that when patients are classified as a stage IV, a dietary evaluation is to be completed within 48 hours, with a follow-up evaluation every 2-7 days after, depending on medical stability. In addition, a two-day calorie count is to be conducted when the patient is consuming an oral diet or when the patient is transitioning from tube feedings. Interview with the Assistant Director of Dietary on 8/20/07 identified that an assessment of weight is to be included in the dietary evaluation. Interview with the Assistant Director of Dietary on 8/20/07 identified that an assessment of weight is to be included in the

The following are violations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (e) Nursing service (1) and/or (i) General (2) and/or (6).

8. Based on review of water monitoring documentation, interview and review of facility policy, the facility failed to ensure that the hemodialysis services performed under a contract, were provided in a safe manner. The findings include:

a. Review of the hemodialysis water monitoring documentation identified that for the period of 7/10/07 through 7/19/07, the facility failed to have documentation of daily water monitoring. Interview with the Facility Administrator indicated that during that period of time the facility was utilizing deionization (DI). Review of the facility policy Water Treatment Systems Minimum Components failed to identify the frequency of water monitoring when DI was in use. Review of the daily water treatment system form identified that the form was to be utilized daily if the facility was using RO or DI.

9. Based on observations, review of medical records, review of hospital policies and procedures and interviews, the hospital failed to ensure that a safe environment was provided for patients. The findings include:

a. Observation during a tour of the Emergency Department on 11/28/07, identified that the four patient cubicles/beds in the Chest Pain Center (CPC) did not have call bells in place. Subsequently after this identification, call bells were installed for these four cubicles/beds by hospital staff.

b. Patient #114 was admitted to the hospital on 11/14/07, via the Emergency Department, with the diagnosis of a right hip infection in a surgical site. The patient's medical history included status post right hip fixation, impaired cognition, hemodynamic instability with cardiac arrhythmia, Diabetes Mellitus, electrolyte abnormalities, altered range of motion and Vancomycin Resistant Enterococcus in the right hip wound. Observation of care, on 11/29/07 during a bath provided by Patient Care Assistant (PCA) #4 and RN #5, identified that at the start of the bath the PCA pulled a curtain around Patient #114's bed although the curtain was not large enough to be pulled around the entire bed and during the bath a volunteer entered the patient's room and was able to watch the patient being washed by the staff. In addition, random room checks identified that in four other patient rooms the curtain was not large enough to be pulled around the patient's bed area.

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10. Based on medical record review, review of hospital documentation and interview, the facility failed to ensure that one patient (Patient #178) remained free from abuse and/or that allegations of abuse were reported in accordance with facility policy for two sampled patients (Patients #178 and 179). The findings include:

a. Patient #178 was admitted to the Behavior Unit on 1/7/08 at 2:40 PM with a diagnosis of acute exacerbation of schizoaffective disorder with delusions. The psychiatric assessment dated 1/7/08 identified that the patient had a history of physical aggression with staff and did not have suicidal/homicidal ideation. The assessment also indicated that the patient was non- medication compliant. The Interdisciplinary Treatment Plan (ITP) dated 1/7/08 included approaches to encourage medication and treatment compliance. Nursing narratives dated 1/7/08 identified that the patient refused to follow directions or limits, refused medications that would assist in calming the patient, and the patient became very threatening toward staff. On 1/7/08, a "staff assist " was called per the direction of the nurse, and the patient was subdued, medicated, and restrained at 4:45 PM per physician orders. MD #37 assessed the patient on 1/7/08 at 11 PM and documented that the patient had a small abrasion on the lower inner lip, left conjunctival injection (bloodshot eye), and swelling above the right eye. Review of hospital documentation dated 1/7/08 noted that RN #3 observed PCA #8 punch Patient #178's side of the head 3- 4 times during the "staff assist " when the patient was on the floor. Interview with PCA #8 on 2/11/08 denied that he had punched Patient #178 on 1/7/08. Although interview with Officer #1 on 2/11/08 indicated that PCA #8 did not punch the patient, interview with RN #3 and Social Worker (SW) #1 on 2/11/08 identified that they were standing and observing the staff assist on 1/7/08. RN #3 and SW #1 observed the patient's head turned toward the patient's right side and PCA #8 punched Patient #178 two to four times in the face/head. SW #1 identified that she did not report what she had witnessed until 1/8/08 when she was questioned by Administration. Interview with the Off- Shift Administrator on 2/20/08 at 11:30 AM noted that staff did not notify her of the alleged event, however became aware of the alleged patient mistreatment on 1/7/08 at approximately 10: 30 PM when she viewed the event report on the computerized event reporting system. Interview with the Psychiatric Service Manager on 2/26/08 at 9 AM identified that the patient was interviewed on 2/11/08 regarding the incident and the patient denied that he had been punched. Interview with Person #2 on 2/26/08 at 9:45 AM noted that Person #2 visited the Patient on 2/8/08. The patient reported to Person #2 that the patient had been choked and punched by staff on 2/7/08. Person #2 identified that one of the patient's eyes was very bloodshot and the patient had trouble seeing out of the eye. The hospital policy for Critical Event Reporting identified, in part that observed or reported inappropriate contact between patients and staff will be reported. During off-hours (e.g. evenings, nights, weekends and holidays), the charge nurse, or designee, will notify the Off- Shift Administrator and the Off-Shift Administrator will notify the Clinical Director.

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In addition, Patient #178 was 27 years old. Interview with the Psychiatric Service Manager on 2/11/08 at 10:30 AM noted that the facility investigation did not substantiate the allegation of abuse involving Patient #178. Further interview with the Psychiatric Service Manager on 2/28/08 at 1:40 PM indicated that the alleged event dated 1/7/08 was not reported to outside agencies or the police. The hospital abuse policy identified that a vulnerable adult included an adult who lacked the physical or mental capacity to provide for his/her daily needs due to mental illness and was between the ages 18 and 59. All cases of suspected abuse and/or neglect must be reported to The Office of Protection and Advocacy for Persons with disabilities via an oral report within 72 hours of the alleged event. A written report must follow within five additional days of the oral report.

b. Patient #179 was admitted to the hospital, on 3/4/07, via the Emergency Department with the complaint of hearing voices that directed him to hurt himself and was admitted with the diagnosis of substance induced mood disorder and cocaine dependence. Patient #179's medical history included asthma, substance induced psychosis, substance abuse of cocaine, alcohol and cannabis, self-mutilation and impulsive behaviors leading to violence. Interview with RN #3, on 2/28/08, alleged that a staff member used force during a manual restraint on 3/8/07 involving Patient #179. Interviews with the Administrative Director and RN #3, on 3/3/08, identified that RN #3 reported the suspected abuse during a hospital wide staff meeting on 3/21/07. Review of the hospital policy and procedure, titled " Abuse: Identification and Management of Patients Suspected to Have Suffered Physical Abuse/Neglect, Emotional Abuse/Neglect, Domestic Violence, Sexual Abuse "last updated 9/1/03", identified that the nurse will assess patients for suspected abuse and initiate the appropriate protocols/referrals.

11. Based on clinical record review, interviews and review of hospital policy and procedures for one patient (Patient #179) that required safe use of a restraint, the hospital failed to ensure that the restraint was implemented with safe techniques. The findings include:

a. Patient #179 was admitted to the hospital, on 3/4/07, via the Emergency Department with the complaint of hearing voices that directed him to hurt himself and was admitted with the diagnosis of substance induced mood disorder and cocaine dependence. Patient #179's medical history included asthma, substance induced psychosis, substance abuse of cocaine, alcohol and cannabis, self-mutilation and impulsive behaviors leading to violence. Review of the progress notes, dated 3/13/07, identified that the patient was agitated and displayed menacing and verbally abusive behaviors to include threats towards staff. The note further indicated that Patient #179's body was moved, during a "take down", to the floor, by MC #4, while a staff assist was called to initiate manual restraint of the patient. Interview with RN #25, on 2/29/08, identified that on 3/13/07 after the take down, Patient #179 was lying on the floor and MC #4 had a hand at Patient #179's neck, the patient was complaining that he had difficulty breathing, RN #25 directed MC #4 to remove his hand from the patient's neck twice and MC #4 did not respond by either moving his hand and/or easing the pressure on the patient's neck. In addition RN #25 identified that she and RN #26 educated MC #4, after the conclusion of the staff assist for Patient #179, on that the appropriate hand placement during a manual restraint and the hand placement was not to be on the patient's neck, as this could restrict the airway. Interview with

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RN #26, on 2/29/08, identified that on 3/13/07 she had to remove MC #4's hand from Patient #179's neck area, while the patient was on the floor during the manual restraint. Additionally RN #26 identified she educated MC #4 on proper hand placement during a manual restraint. Interview with MC #4, on 3/3/08, identified that during the staff assist for the manual restraint of Patient #179 on 3/13/07 RN #26 did remove his hand from the patient's body and following the manual restraint RN #25 and RN #26 did educate him that hand placement at a patient's neck was not appropriate. Interview with the Clinical Nurse Educator, on 3/3/08, identified that during a manual restraint the staff is not to place their hands and/or any body part on the patient's neck and/or chest. Review of the hospital policy and procedure, titled "Restraint and Seclusion Policy", identified that in part that least restrictive restraint measures are used to maintain the safety of the patient.

The following is a violation of the General Statutes of Connecticut Section 46a-152(d) and/or the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (e) Nursing service (1) and/or (i) General (6).

12. Based on clinical record review, observations and interviews with facility personnel, the facility failed to ensure that a physicians order was obtained prior to applying restraints for Patient #103. The findings include:

a. Patient #103 was admitted to the hospital on 11/26/07 with coronary artery disease. Observation of the patient on 11/28/07 at 2pm identified that the patient was sitting up in a chair with bilateral wrist restraints applied. Review of the physician's orders dated 11/27/07 identified that the patient had no order for the restraints. Further review identified that a physicians order was obtained on 11/28/07. Review of the nursing flowsheets dated 11/27/07-11/28/07 identified that the patient had the restraints applied on 11/27/07 at 8pm. Review of hospital policy identified that a physician order is required before applying restraints.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical staff (2)(B) and/or (4)(A) and/or (d) Medical records (3) and/or (e) Nursing service (1) and/or (f) Diagnostic and therapeutic facilities and/or (g) Pharmacy (1) and/or (i) General (6) and/or (l) Infection control (1)(A).

13. Based on clinical record review and staff interviews, the facility failed to provide documentation that a physician viewed a CT scan report of a postoperative patient, Patient #133, who required additional surgery to remove a lap sponge. The findings include:

a. Patient #133 had been admitted into the facility on 5/28/07 with nausea and vomiting and experiencing right upper quadrant pain. Review of the clinical record identified that Patient #133 had an open cholecystectomy performed on 5/28/07 by MD #33. Review of MD #33's operative report identified that all sponge and needle counts were correct at the end of the case. Review of the clinical record identified that Patient #133 on 5/29/07 and 5/30/07, experienced multiple episodes of dark coffee grounds/hematemesis. MD #33 ordered a GI consult, done on 5/31/07, which identified esophagitis with no active bleeding. A hematology consult was

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obtained on 5/31/07. Review of MD #34's (Hematology) progress notes dated 6/2/07 identified that the patient had a cold agglutinin disease secondary to lymphoproliferative disorder and ordered a chest/ pelvis and abdomen CT scan for lymphoma work-up.
Review of the CT scan results dated 6/3/07 signed by MD #35 (Radiologist) identified collections at the surgical site in the right upper quadrant having the typical appearance of surgical packing material (for example Surgicel) and recommended correlation with the use of products to exclude the prospect of an abscess.
Interview with MD #33 on 1/23/08 at 9AM identified that a Resident had made her aware of the 6/2/07 CT scan finding results via telephone, and that the Resident had asked her if she had used Surgicel to which she stated she did. Interview further identified that MD #33 did not go to view the CT scan. Review of the clinical record failed to identify documentation that MD #35 had communicated the CT scan results to MD #34 and/or MD #33 and/or that the CT scan results were viewed by a physician following the radiologists reading. Patient #133 was readmitted on 10/16/07 with a diagnosis of a possible Small Bowel Obstruction. Review of MD #33's operative note dated 10/16/07 identified the postop diagnosis of a retained surgical laparotomy pad with duodenal perforation and obstruction.

14. Based on clinical record reviews, review of Hospital by-laws and interviews, the hospital failed to ensure for Patients #105 and 106, that the medication orders were complete. The findings include:

a. Patient #105 was admitted to the Emergency Department on 11/27/07 at 9:10 PM with the complaint of right sided chest pain that radiated to his back with episodes of shortness of breath and was diagnosed with chest pain. Review of the patient's medical record identified that two medication orders (Motrin and Oxycodone) were incomplete; both orders lacked the frequency of administration of the medication.
b. Patient #106 was admitted to the Emergency Department, on 11/27/07 at 6:06 P.M., with the complaint of chest pain that radiated to the left arm for one day and was diagnosed with chest pain. Review of the patient's medical record identified that three medication orders (Maalox, Lidocaine and Tylenol) were incomplete; the orders lacked the frequency of administration of the medication. Interview with the Emergency Department Nurse Manager, on 12/6/07, identified that the frequency for the medication orders written in the Emergency Department are not documented.

15. * Based on observations, clinical record review, staff interviews, review of facility documentation, policy and/or protocol and practice guidelines, the facility failed to ensure that a registered nurse supervised and/or evaluated the nursing care for Patients #102, 103, 105, 106, 110, 114, 137, 138, 143, 151, 156, 157, 159, 164, 165, 168, 169, 171, 172 and 178. The findings include:

a. Patient #143 was admitted to the hospital on 11/14/07 with acute renal failure and was subsequently started on hemodialysis. Review of the hemodialysis orders dated 11/26/07 directed that the patient be dialyzed with a two (2) Potassium bath and receive 2,000 units of heparin pre treatment. Review of the flow sheet dated 11/26/07 indicated that the patient had been dialyzed with a three (3) Potassium bath and received 2,000 units of Heparin pre treatment and 1,000 units during the treatment.

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b. Patient #110 was admitted to the hospital on 11/15/07 for a cardiac biopsy related to amyloidosis and was identified with a Stage II pressure ulcer on admission. Review of the nurse's note dated 11/15/07 identified that the patient had a 2cm by 2cm Stage II ulcer on the coccyx. The nurse's note dated 11/16/07 identified a 4cm by 4cm area on the coccyx however, review of the flow sheet dated 11/16/07 indicated that the patient had a 6cm by 5cm Stage II. Review of the flow sheet dated 11/20/07 indicated a 5.5cm by 2.5cm coccyx ulcer and on the flow sheet dated 11/25/07 the patient was identified with a 7cm by 7cm Stage II coccyx ulcer. Interview with the patient's nurse on 11/28/07 indicated that the patient in fact had five small (approximately 2cm by 2cm) Stage II pressure ulcers on the areas of the coccyx and right buttocks. Review of the clinical record identified inconsistent/inaccurate documentation related to the patient's skin breakdown.

c. Patient #164 was admitted to the hospital on 7/15/07 with shortness of breath and congestive heart failure related to endocarditis, requiring an aortic and mitral valve replacement. The flow sheet dated 8/19/07 identified that the patient had a Stage I pressure area however, the documentation failed to reflect an assessment and/or measurement of the area. Review of the care plan dated 8/7/07 indicated to institute the Clinical Practice Management (CPM) guidelines for pressure ulcer prevention. Review of the clinical record identified on 8/22/07 that the patient had a reddened sacral area (Stage I). Review of the flow sheet dated 8/27/07 indicated that the patient had a Stage II ulcer on the coccyx. The care plan updated on 8/28/07 indicated skin care and support service as prescribed. Review of the nurse's notes for September 2007 identified that the patient was out of bed to the chair. The flow sheets dated 9/19-20/07 indicated that the patient had a Stage II of the coccyx and the flow sheet dated 9/21/07 indicated that the coccyx ulcer was a Stage III. The 9/23/07 flow sheet indicated that the coccyx wound was unstageable. Review of the skin CPM guidelines identified the use of a chair pad however, interview with the Wound Care Nurse identified that the facility utilized egg crate mattresses rather than pressure relieving devices.

Although the flow sheet dated 9/24/07 indicated that duoderm had been applied to the patient's spine, documentation failed to reflect an assessment of the area. Review of the flow sheets dated 9/30/07 and 10/04/07 indicated that the patient had a stage I to the thoracic spine but documentation failed to reflect an assessment of the area. Subsequently, the flow sheet dated 10/5/07 indicated that the patient had two Stage II ulcers on the thoracic spine that were 1cm by 1cm.

d. Patient #165 was admitted to the facility on 8/15/07 with Congestive Heart Failure exacerbation and to rule out a Pulmonary Embolism. Review of the physician's orders dated 8/25/07 directed that the patient be weighed daily. Review of the flow sheet for the period of 8/25/07 through 10/03/07 failed to identify that the patient had been weighed on fifteen (15) of the forty (40) days.

Review of the clinical record indicated that the progress note dated 9/2/07 indicated that Patient #165 had a clot in the right arm. The physician's orders dated 9/2/07 directed warm soaks to the right upper extremity for thirty to sixty minutes four to five times daily. The clinical record failed to identify an assessment of the right arm and although the progress note dated 9/2/07 indicated that the right arm was elevated and warm soaks applied and the note dated 9/4/07 at

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2:50 AM indicated that the patient had a right arm deep vein thrombosis (DVT) by a doppler scan and that warm soaks had been applied, documentation failed to reflect how long the warm soaks had been applied. Review of the care plan dated 9/12/07 failed to identify that the plan of care had been updated to address this issue. Review of the nursing flow sheet dated 8/25/07 indicated that the patient had a Stage I pressure area of the coccyx. The flow sheet dated 8/27/07 indicated that the patient had Stage I pressure areas on the coccyx and heels. Documentation failed to reflect that an assessment/measurement of the areas had been completed. Patient #165 subsequently developed five Stage II pressure areas on the coccyx with the flow sheet dated 9/6/07 indicating that the patient had a 7.5cm by 6 cm un-stageable area of the coccyx.

e. Patient # 137 was admitted to the hospital on 12/3/07 in labor. Review of a physician's order dated 12/3/07 at 8:24 am directed that a continuous infusion of intravenous (IV) oxytocin be started at 1-2 milliunits/minute for augmentation of labor and to increase the oxytocin by one (1) to two (2) milliunits/minute every fifteen (15) minutes for two (2) hours then every thirty (30) minutes to achieve contractions no closer than two (2) to three (3) minutes apart. Review of the clinical practice guideline for oxytocin therapy directed that assessment of the fetal heart rate, uterine contraction pattern and uterine intensity be documented every fifteen (15) minutes before increasing the dose of oxytocin. Although review of the labor record dated 12/3/07 during the period of 8:38 AM through 11:12 am with the Nurse Manager for the Labor & Delivery unit identified that oxytocin was increased from two (2) milliunits/minute to eight (8) milliunits/minute, the clinical record failed to identify that the patient's uterine intensity was monitored in accordance with facility protocol. Interview with RN #17 on12/3/07 identified that she was unaware that the protocol directed fifteen-minute minute monitoring of the patient's uterine intensity status.

f. Patient #138 was admitted to the hospital on 12/2/07 in labor. Review of a physician's order dated 12/2/07 at 4:41 am directed an intravenous (IV) bolus of Magnesium Sulfate, four (4) grams be administered followed by a continuous IV infusion of Magnesium Sulfate maintained at two (2) grams per hour. Review of the clinical practice manual directed that frequency of contractions, patient's perception of contraction strength and duration of the contraction be documented every one (1) to two (2) hours during the continuous infusion of magnesium sulfate. Although review of the labor record dated 12/2/07 and interview with the Nurse Manager identified that the patient was maintained on a continuous infusion of Magnesium Sulfate as prescribed, the facility failed to ensure that the patient's perception of contraction strength and/or duration of the contraction was consistently assessed and documented in accordance with facility protocol.

g. Patient #157 was admitted to the oncology gynecology clinic on 12/4/07 at 12:00pm for chemotherapy treatment. Review of the initial nursing assessment dated 12/4/07 failed to identify that an assessment (including vital signs, pain and any side effects to previous treatments) was completed prior to the patient receiving chemotherapy. Observation of Patient #157 on 12/4/07at 1:45pm identified the patient was receiving a chemotherapy treatment. Review of hospital policy identified that that an initial assessment is to be completed including side effects of previous therapy prior to the administration of chemotherapy treatment.

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h. Patient #171 was admitted to the Emergency Department on 8/17/06 after being struck by a motor vehicle. Patient #171 sustained a right proximal fibula fracture. Patient #171 was seen by an orthopedic surgeon and the plan was for the patient to wear a knee immobilizer and outpatient follow-up. At 3:40am, while Patient #171 was sitting up, he felt dizzy, passed out and had an un-witnessed fall resulting in a non-displaced nasal fracture and facial lacerations. Patient #171 was to be admitted to a telemetry bed for syncope work up and observation. Review of the nursing flowsheet dated 8/17/06-8/18/06 identified that the patients vital signs were stable however further review identified that although a neurological assessment was completed at 3:40am, subsequent neurological assessments were not completed until 6:00am and 8:30 a.m. (21/2 hours apart). Review of the progress notes dated 8/18/06 at 9:00am identified that Patient #171 indicated his desire to leave against medical advice at 8:56am. Review of hospital policy identified that neurological checks are to be completed when a patient has a fall with a head injury and/or per physicians order. Although facility policy identifies that ongoing reassessment should be individualized in collaboration with the physician, the clinical record did not include orders for subsequent neurological assessment. Interview with the ED Nursing Director on 1/3/08 indicated that the standard for neurological checks in the Emergency Department is every four hours however they should be done more frequently for patients with a head injury.

i. Patient #156 was admitted to the hospital on 5/15/07 with a PICC line infection. Patient #156 also had an unstageable sacral pressure ulcer on admission. Review of the nursing admission assessment dated 5/15/07 identified that the patient's Braden Assessment Score was 11 (high risk for pressure sores). On 5/18/07, the patient was placed on an Eclipse bed. On 6/25/07, it was identified that the patient had an unstageable pressure sore to the right hip. Review of the nursing flowsheets dated 5/15/07-12/5/07 failed to identify that assessments and monitoring of the patients skin were completed every shift per hospital policy. Further review failed to identify that the patient's wounds were assessed, measured and monitored consistently. On 12/5/07, observation of Patient #156's wounds indicated that the patient had a healing Stage III to the sacral area measuring 6cm X 4.5cm, right heel 2.5cm X 2cm, left heel unstageable area 2.5cm X 2cm, and Stage IV to the right hip measuring 2.5cm X 3.5cm X 3.5cm with 4cm of undermining and a Stage II pressure area to the left ear. Review of hospital policy identified that documentation of skin breakdown areas include location, stage, size, color of ulcer bed, the presence of exudates, odor, pain and/or erthema and evaluation of the surrounding skin. Interview with the Nursing Director of Medicine on 12/5/07 identified that the patient's skin is to be assessed daily and measurements are to be completed weekly. In addition, review of admission dietary consults dated 5/17/07 identified that the patient's weight was 187 lbs with interventions to obtain a weight weekly. Further review of dietary consults dated 5/07-11/07 identified continued recommendations to weigh now and weekly, however review of the nursing flowsheets dated 5/18/07-11/16/07 identified that no weight was completed for Patient #156. Patient #156 was weighed on 11/16/07 233 lbs (5 months later) at which time a weigh gain of (46 lbs) was identified. Interview with the Nursing Director of Medicine on 12/5/07 identified that the patient should have been weighed per dietary recommendations.

j. Patient #105 was admitted to the Emergency Department on 11/27/07 at 9:10 P.M., triage level

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3, with the complaint of right-sided chest pain that radiated to his back with episodes of shortness of breath and was diagnosed with chest pain. Review of the patient's medical record identified that at midnight, on 11/28/07, Patient #105 was transferred to the Chest Pain Center and subsequently the documentation failed to identify that nursing assessments were completed for this patient, although it was identified that Patient #105 had diagnostic tests, interventions and treatments completed. The Emergency Department triage acuity level document identified that a patient that is a triage level 3 and the reassessment by the Registered Nurse is to be performed every two hours or more frequently, dependent on the patient's condition.

k. Patient #106 was admitted to the Emergency Department, on 11/27/07 at 6:06 P.M., triage level 2, with the complaint of chest pain that radiated to the left arm for one day and was diagnosed with chest pain. Review of the patient's medical record identified that at 8:30 P.M. on 11/27/07, Patient #106 was transferred to the Chest Pain Center. Review of the clinical record dated 11/27/07 at 8:30 P.M. to 11/28/07 at 7:40 A.M., failed to identify documentation of nursing assessments, although it was identified that Patient #106 experienced chest pain and had undergo diagnostic tests, interventions and treatments completed. Review of the hospital Emergency Department policy, titled "Assessment of Patients", identified that patient assessment is ongoing, the assessment of the patient is outlined by the triage level assigned and/or more frequently depending on the patient's condition and the assessment includes results of diagnostic tests and patient responses to interventions and treatments. In addition the Emergency Department triage acuity level document identified that a patient that is a triage level 2 and the reassessment by the Registered Nurse is to be performed every thirty minutes or more frequently. Review of the hospital document, titled "Chest Pain Center, Patient Information", identified that nurses will be available to provide care.
In addition, the medical record identified that at 8:35 P.M., 11:45 P.M., and at 7:50 A.M., Patient #106 received Tylenol, Nitroglycerin Paste and Tylenol, respectively, for pain however, the record failed to identify that the patient was reassessed for pain after these interventions. Review of the hospital policy and procedure, titled "Pain", identified that the patient is reassessed for pain within one hour after any intervention-including medications.

l. Patient #114 was admitted to the hospital on 11/14/07, via the Emergency Department, with the diagnosis of a right hip infection in a surgical site. The patient's medical history included status post right hip fixation, impaired cognition, hemodynamic instability with cardiac arrhythmia, Diabetes Mellitus, electrolyte abnormalities, altered range of motion and Vancomycin Resistant Enterococcus in the right hip wound. Observation of care, on 11/29/07, identified that Patient #114 had nasal oxygen in place at a rate of one liter per minute. Review of the medical record identified an order to administer oxygen at two liters per minute via nasal cannula to treat hypoxemia. Interview with RN #5, on 11/29/07, identified that she was weaning the patient off the oxygen; although the physician order is to administer oxygen at two liter per minute and there is no physician order to titrate the oxygen.
In addition, observation of care provided to Patient #114, on 11/29/07 by RN #5, identified that during dressing changes RN #5 was observed to contaminate clean dressing supplies and gloves by throwing the items onto a soiled bed, failed to wash her hands between glove changes and failed to secure the isolation gown in place while providing care to the patient. Review of the

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hospital clinical practice manual, titled "Open Wounds, Care of the Adult Patient with", identified that between glove changes if the hands are visibly soiled hand hygiene must be performed.

m. Patient #169 was transported to the Emergency Department on 10/19/07 at 5:05 P.M., via ambulance, was triaged as a level 2 with the complaint of out of control behavior (was in a fight) at a residential treatment program and was diagnosed with aggressive behavior. Patient #169's medical and psychosocial histories included mood disorder, impulse control disorder, a twelve-year history of violence towards self and others and multiple failed placements. Review of the medical record failed to identify that the substance abuse screen was completed when Patient #169 was transferred to the Crisis Intervention Unit (CIU) area.
Review of the Nursing Note lacked documentation of a nursing assessment of the patient on 10/20/07 at 7:30 A.M. to discharge at 10:22 A.M. Interview with the Emergency Department Nurse Manager, on 12/7/07, identified that the nurse did not document a nursing assessment for Patient #169 on 10/20/07. Review of the Emergency Department triage acuity level document identified that a patient that is a triage level 2, the reassessment by the Registered Nurse is to be performed every thirty minutes or more frequently, dependent on the patient's condition. Additionally, review of the patient's medical record failed to identify that RN #15 communicated Patient #169's Emergency Department treatment and/or current status to caregivers at the patient's residential program. Interview with the Emergency Department Nurse Manager, on 12/7/07, identified that there is no documentation of discussion of the residential program staff about the patient's condition at time of discharge, although documentation identified that the program staff was contacted on 10/19/07 after the patient was admitted. Review of the medical record failed to identify that RN #15 had completed discharge instructions for Patient #169 and/or for the caregivers for Patient #169. Interview with the Emergency Department Nurse Manager, on 12/7/07, identified that no discharge instructions were completed for this patient. Review of the hospital Emergency Department policy and procedure, titled "Patient Discharge and Follow-up Care", identified that patients that are transferred to another facility for treatment require a document (W10) to communicate to the receiving facility the Emergency Department treatment and interventions completed. The hospital Emergency Department policy and procedure, titled "Assessment of Patients", identified that at time of discharge all assessments are documented and the assessment is communicated to the patient and/or the patient's usual caregiver. In addition review of the hospital policy and procedure, titled "Discharge/Transfer of Non-Emergent Patient to Another Health Care Facility for a Lower Level of Care", identified that the nurse providing care will communicate to the receiving facility the patient's hospital course and condition on discharge, pertinent clinical information and transportation information.

n. Patient #168 was admitted to the Emergency Department on 5/23/07 at 10:55 P.M., triage level 3, with the complaint of abdominal pain and no bowel movement for the last five days. Patient #168's medical history included rectal cancer, status post colostomy and ileoconduit (in 2003) and current chemotherapy regime. Review of the "Nursing Note" assessment dated 5/23/07, failed to identify the patient's level of pain. Interview with the Emergency Department Nurse Manager, on 12/7/07, identified that this patient's pain level was not documented, although the

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patient's pain level had been assessed in the triage area earlier.
Review of the Nursing Note assessment dated 5/23/07, identified that the "substance Abuse Screening" which includes information about the patient/family social history, functional history and support systems available, was not completed.
Additionally, review of this assessment failed to identify that the nurse had documented an assessment of Patient #168's genitourinary system, although the patient had a history of a surgical urinary ostomy system. Interview with the Emergency Department Nurse Manager, on 12/7/07, identified that the assessment was not documented.
The medical record identified that on 5/24/07 at 1:00 AM and at 2:15 AM. Patient #168 was medicated for pain with Morphine 4.0 milligrams via intravenously, although documentation was lacking that the patient's pain level was reassessed after this intervention. Interview with the Emergency Department Nurse Manager, on 12/7/07, identified that there is no documentation of this patient's level of pain after the medication intervention. Review of the hospital policy and procedure, titled "Pain", identified that the patient's pain level is reassessed within one hour after any intervention.
Review of five "Record of Transfusion" documents for Patient #168 (pertaining to blood and/or blood product administration) failed to identify documentation of the date started and/or time started and/or date ended and/or time ended and/or if the administration was satisfactory or not and/or verification of the product by two qualified hospital personnel. Interview with the Nurse Manager of 6-7, on 12/6/07, identified that the necessary documentation of blood and/or blood product administration, on the "Record of Transfusion", includes the date and time started, the date and time ended and if the administration was satisfactory or not. Review of the hospital policy and procedure, titled "Blood/Blood Components", identified that a Registered Nurse and a qualified second verifier must verbally verify selected information and then sign the transfusion document, and documentation of the transfusion includes date and time of start, date and time of ending and if the transfusion administration was satisfactory or not.
Review of the "7 Day Medication Summary" identified that on 5/24/07 at 4:00 P.M. Patient #168 was given Dilaudid 1.0 milligram intravenously. Review of the "Adult Med/Surg Flowsheet", for the same time, lacked an assessment of the patient's pain level and/or a reassessment of the patient's pain level after the identified intervention. Review of the hospital policy and procedure, titled "Pain", identified that the patient's pain level is to be assessed prior to any pain relieving intervention and the patient is to be reassessed within one hour after any intervention.
Additionally, review of the daily "Adult Med/Surg Flowsheet", dated 5/25, failed to identify that a comprehensive assessment was documented for Patient #168 by RN #13-including assessment of the patient's respiratory system, gastrointestinal system and genitourinary system. Interview with RN #13, on 12/7/07, identified that she was not aware why documentation was lacking.
In addition, review of the physician's orders, dated 5/24/07 at 2:15 A.M., directed the staff to alert the physician on call if the patient's temperature is 100.8 degrees Fahrenheit or greater. Review of the medical record failed to identify that RN #13 informed and/or updated a physician when Patient #168 had temperatures of 102.0 degrees F and 101.0 Degrees F. Interview with PA #1 and MD #24, on 12/7/07, identified that the nurse did not call the

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practitioners about the patient's febrile state at 8:00 A.M. and 12:00 Noon.
Review of the physician orders, dated 5/25/07 at 9:48 A.M., directed the staff to administer oxygen to Patient #168 at one to two liters per minute via nasal cannula, to treat proven hypoxemia. Review of the medical record failed to identify that RN #13 administered any oxygen as ordered to Patient #168, although documentation identified that the patient was maintained on room air from 12:00 Noon to 4:00 P.M.
In addition although review of the physician orders, on 5/25/07 for the period from 09:00 A.M. to 4:13 P.M., identified that the patient received new treatments, interventions, diagnostic tests and consults to address changes in status-including changes in blood pressure, temperature, heart rate, respiratory rate and oxygen saturation, although a nursing reassessment was not documented. Interview with RN #13, on 12/7/07, identified that no reassessment of the patient was completed, although the patient did have a change in condition. Review of the hospital policy and procedure, titled "Documenting the Nursing Process", identified that assessment of a patient is "a deliberate and systematic collection focused on the unique needs and desires of the patient and family" and the assessment process is ongoing.

o. Patient #172 was admitted to the hospital on 11/14/07 with the diagnosis of breast cancer and past medical history of hypertension, hypothyroidism, and chronic low back pain. On 11/14/07 Patient #172 had a right total mastectomy and reconstruction with muscle-sparing free transverse rectus abdominis myocutaneous flap, a left breast mastopexy, exploration of right internal mammary vessels with removal of a rib segment, and abdominal wall reconstruction, that started at 8:19 A.M. and ended at 11:01 P.M. Review of the Perioperative Plan of Care, for Patient #172 dated 11/14/07, identified documentation by RN #21 that the final sponge count was incorrect, MD # 31 was notified, a sponge recount and room search were done and x-rays were ordered (chest and abdominal) and performed. Review of the x-rays results identified that there was no evidence of sponges in the abdomen and/or lower chest. Review of the Progress notes, by the surgical medical team, from 11/16/07 to discharge on 11/20/07, identified that Patient #172 developed a hematoma on the right anterior breast and mid-axillary area, although review of the nursing documentation failed to identify any assessments of the area-including location and size of the hematoma. Interview with MD #31, on 1/23/08, identified that a hematoma formation postoperatively, for the surgery that was performed on Patient #172, was not routine. Interview with the Nursing Director of Surgery, on 3/3/08, identified that there is no standard for nursing documentation of a hematoma. Review of the hospital policy and procedure, titled "Documenting the Nursing Process", identified that assessment is a continuous, deliberate and systematic collection of data by the Registered Nurse focused on each patient's unique needs in order to identify and/or address patient problems.
In addition, review of the physician orders, dated 11/16/07 at 4:38 P.M., directed the staff to transfuse one unit of red blood cells to Patient #172. Review of the Adult Medical Surgical Flow Sheet, dated 11/16/07, identified that unit number 33GS94662 was infused, although documentation was lacking that the blood tag (the yellow compatibility form) was completed and/or the information that two Registered Nurses verified the product prior to infusion-and signed the blood bank tag, the date and exact time started, the date and exact time ended, the signature of the nurse that infused the product and the amount of product infused. Interview

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with the hospital Risk Management Specialist, on 1/24/08, identified that the blood bank tag (the yellow compatibility form) could not be located for this patient's transfusion on 11/16/07. Review of the hospital policy and procedure, titled "Blood/Blood Components", identified that the yellow compatibility form is to be completed, that a Registered Nurse (RN) and another verifier (RN, MD or Licensed Independent Practitioner) must verify the product prior to infusion and those two must sign the blood bank tag, and documentation of the product transfusion includes-start and end dates and times, the volume infused and the name of the staff that infused the product.

Review of the clinical record identified that postoperatively Patient #172 was assessed to have pain, interventions were used to address the pain-including the use of a pillow for splinting and administration of an opioid analgesics (Lortab 5/500) as directed by the physician, although documentation was not identified that the patient was reassessed for pain after the administration of pain medication on two occasions (11/16/07 at 9:35 P.M., 11/17/07 and at 12:10 P.M.). Interview with the Nursing Director of Surgery, on 3/3/08, failed to present any information regarding pain reassessments for this patient. Review of the hospital policy and procedure, titled "Pain (Adult)", identified that the patient is to be reassessed within one hour after any intervention.

p. Patient #178's diagnosis included acute exacerbation of schizoaffective disorder with delusions. The emergency department assessment and nursing assessment dated 1/7/08 identified that the patient ' s skin was within normal limits and intact. Nursing narratives dated 1/7/08 identified that the patient became very threatening toward staff and the patient was subdued, medicated, and restrained at 4:45 PM per physician orders. Although the nursing narrative indicated that the patient struggled, and the nurse assessed the patient's behavior, the nurse did not document an assessment of the patient's physical status. MD #37 assessed the patient on 1/7/08 at 11 PM (6 hours after the incident) and documented that the patient had had a "bloody lip" after being placed in restraints earlier in the evening. The patient had a small abrasion on the lower inner lip, left conjunctival injection (bloodshot eye), and swelling above the right eye. The hospital policy for Critical Event Reporting identified, in part that the charge nurse will document any patient- related event in a progress note. The Clinical Nurse will assess the patient at the time of the incident or injury and will reassess the patient within one hour after the injury.

q. Patient #151 was admitted into the facility on 11/21/07 with an initial nursing body assessment that identified the patient had a 2 ½ cm x 3 ½ cm Stage 2 on the right buttocks with no odor or exudate. Nursing notes dated 11/23/07 and 11/25/07 identified that zinc oxide had been applied to the Stage II pressure ulcer on the left buttocks. Review of the nursing flow sheet dated 11/27/07 identified that Tegasorb had been applied to the left buttocks. On 11/30/07, the flow sheet identified that zinc oxide and 3m barrier spray had been applied to the Stage II on the left buttocks. Observation on 12/5/07 at 10:30 AM identified a pressure ulcer on the left buttocks covered with a tegasorb. Review of the physician orders from 11/22/07 through 12/4/07 identified the application of barrier spray to the sacral Stage1 ulceration. Documentation failed to consistently identify the location as the left buttocks. Review of the facility pressure ulcer prevention and treatment policy for a Stage II directed treatment interventions of a transparent dressing if minimal exudate was present, that a hydrocolloid dressing may be considered and

that a Xeroform dressing be considered if dressing adherence was a problem.

r. Patient #159 was admitted to the hospital on 11/14/07 with an ischemic stroke. Review of the admission nursing assessment dated 11/14/07 identified that the patient's skin was intact and his Braden Assessment Score was 15 (18 or less equals a risk for pressure ulcers). Review of the nursing flowsheets dated 11/23-11/30/07 identified on 11/26/07, Patient #159 developed a Stage II pressure sore on the coccyx measuring 3cm X 3cm that healed on 11/29/07. Observation of Patient #159 on 11/30/07 identified that the patient was sitting up in a recliner chair without any pressure relieving cushion. Further observation on 11/30/07 identified that the patient had Stage I to the coccyx with two pin sized Stage II areas on the upper coccyx. Review of hospital policy identified that patients who are identified to be at risk are to have pressure relieving cushions applied when out of bed. Interview with the 6-3 Nurse Manager on 11/30/07 identified that the patient had a pressure relieving cushion but it was not utilized.

s. Patient #103 was admitted to the hospital on 11/26/07 with coronary atherosclerosis and and underwent a CABG on 11/27/07. Review of the Braden Assessment on 11/28/07 identified that the patient was seven (7) (very high risk for pressure sores). Review of the nursing flowsheet dated 11/28/07 identified that the patient had a Stage I area to the buttocks. Observation of Patient #103 on 11/28/07 at 2pm identified that the patient was up in a chair since 11am (3 hours). Further observation identified that the patient was sitting on a pillow. Observation of Patient #103's buttock area with the Nurse Manager on 11/26/07 identified a large Stage I area over sacral/coccyx area. Review of hospital policy identified that patients who are high risk for pressure sores are to have a pressure relieving device while up in a chair. Further review identified time in a chair should be limited to two hours maximum. Interview with the Nurse Manager of CT/ICU on 11/26/07 identified that Patient #103 needed a pressure relieving cushion while up in a chair and not a pillow.

t. Patient #102 was admitted to the hospital on 9/25/07 with Cardiac Dysrhythmia. Review of the physician orders dated 11/4/07 identified that the patient was to be weighed daily. Review of the nursing assessment dated 10/11/07 identified that the patient's weight was 82 kg (180 lbs). Review of the nursing flowsheets dated 11/5/07 identified that the patients weight was 75.5kg. Futher review identified that the next time the patient was weighed was 11/14/07 (9 days later) with a weight of 71.3kg. (156lbs) (24lb weigh loss). Review of the nursing flowsheets dated 11/4/07-11/19/07 failed to identify that the patient had been consistently weighed per physician order (not weighed 11 times in15 days). Interview with the CT/ICU Nurse Manager on 11/26/07 identified that the physician order was not followed.

The following are violations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical staff (2)(B) and/or (d) Medical records (3) and/or (e) Nursing service (1) and/or (i) General (6).

16. Based on observations, clinical record reviews, staff interviews and review of facility policy, the hospital failed to ensure that nursing staff developed and/or kept current a nursing care plan for Patients #110, 144, 145, 146, 147, 148, 155, 165 and 172. The findings include:

a. Review of the clinical record for Patient #145 identified that the patient had been admitted to

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the hospital on 11/21/07. Review of the therapeutic recreation evaluation indicated that the patient had completed the self-assessment on 11/23/07 and the Recreation Therapist completed the assessment on 11/26/07. Interview with the Manager identified that once the therapeutic recreation evaluation was completed, the groups the patient should attend are identified. Review of the interim treatment plan dated 11/21/07 failed to identify an interim plan and/or the groups the patient should attend prior to the completion of the Therapeutic recreation assessment.

b. Patient #146 was admitted to the Intensive Outpatient Program (IOP) on 11/9/07. Although the current treatment plan identified the patient was to attend groups, the interventions failed to identify which specific groups the patient was to attend and the frequency that the patient was to attend the IOP.

c. Patient #147 was admitted to the hospital on 11/18/07. Review of the treatment plan dated 11/20/07 identified that the functional/rehabilitation problem area had not been completed and although the treatment plan identified the patient was to attend group meetings, the interventions failed to identify which specific groups the patient should attend. Review of the group notes identified that during the period of 11/18/07 through 11/30/07, the patient attended one group. The treatment plan failed to be updated to address alternative interventions during that period.

In addition, review of the clinical record identified that on 11/27/07 the patient was identified with Methlicillin Resistant Staphlycoccus Aureous (MRSA) in the urine. Tour indicated that the patient had a contact precaution sign posted at then entrance to his room. The clinical record and/or treatment plan failed to reflect patient teaching related to the new diagnosis and/or isolation procedures.

d. Patient #148 was admitted to the hospital on 11/23/07. Review of the current treatment plan on 12/3/07 although identifying the patient was to attend groups, the interventions failed to reflect the specific groups the patient was to attend.

e. Patient #155 was admitted to the hospital on 11/26/07. Although the treatment plan contained an assessment of alternative strategies, de-escalation tool and the patient's strengths and weaknesses, it failed to identify specific interventions related these problems on the Master Treatment Plan (MTP). Review of the treatment plan policy identified that treatment interventions required to meet the treatment goals and objectives shall be identified and that treatment planning shall include specialized rehabilitation services to restore or maintain functional abilities.

f. Patient #110 was admitted to the hospital on 11/15/07 for a cardiac biopsy related to amyloidosis and was identified with a Stage II pressure ulcer on admission that measured 2 cm by 2cm. Review of the clinical record identified that on admission, the patient had a Braden Skin assessment completed that indicated that the patient was at high risk (e.g. score of 11) for skin breakdown. Review of the care plan failed to identify that a care plan problem addressing the patient ' s actual skin breakdown and/or preventative care had been implemented until 11/26/07, eleven days after admission.

g. Patient #144 was admitted to the hospital on 11/20/07 with bilateral venous ulcers and a history of Diabetes, Depression, Dementia and cirrhosis. Review of the initial Braden skin assessment

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identified that the patient had a score of eleven (11) identifying the patient at high risk for breakdown. The flow sheet dated 11/25/07 identified that the patient had tegasorb on a heel ulcer and Stage II ulcers on each buttocks that were 1.5cm in diameter and that tegasorb had been applied. Review of the care plan dated 11/20/07 identified that although the patient had an integumentary problem related to the venous stasis ulcers, it failed to identify interventions addressing preventative care once the patient was identified at high risk for breakdown. In addition, the care plan failed to be updated once the patient developed breakdown.

h. Patient #165 was admitted to the facility on 8/15/07 with Congestive Heart Failure exacerbation and to rule out a Pulmonary Embolism. The patient had a past medical history that included Diabetes, gastroesophageal reflux disease, coronary artery disease, chronic obstructive pulmonary disease, hypertension and renal insufficiency. Review of the clinical record indicated that the patient had an initial nutritional assessment on 8/27/07. The assessment indicated the referral was due to the patient's poor intake and restricted diet and identified that the patient was at his ideal body weight of 74 kg. The dietician recommended daily weights, lab work and an appetite stimulant. The nutrition progress note dated 9/21/07 indicated that the patient's weight on 9/20/07 was 63.6 kgs, a 10.4 kg weight loss. The patient remained on tube feedings of Diabetisource at 70 cc's per hour. The nutrition note dated 9/26/07 indicated that the patient's weight on 9/26/07 was 55.1 kg, a total weight loss of 18.9 kgs. Review of the care plan dated 8/25/07, addressed the patient's inadequate nutritional intake with goals that included nutritional intake greater then or equal to 75% of needs and an albumin that would trend positive. However, the only intervention identified on the nursing care plan was to monitor response to medical therapy and for potential complications. Review of the facility documentation policy indicated that the care plan should contain interventions used by the interdisciplinary team to meet the individual needs of the patients.

i. Patient #172 was admitted to the hospital on 11/14/07 with the diagnosis of breast cancer and past medical history of hypertension, hypothyroidism, and chronic low back pain. On 11/14/07 Patient #172 had a right total mastectomy and reconstruction with muscle-sparing free transverse rectus abdominis myocutaneous flap, a left breast mastopexy, exploration of right internal mammary vessels with removal of a rib segment, and abdominal wall reconstruction. Review of the Progress notes, by the surgical medical team, from 11/16/07 to discharge on 11/20/07, identified that Patient #172 developed a hematoma on the right anterior breast and mid-axillary area. Review of Patient #172's plan of care failed to identify and/or address the hematoma that was identified on 11/16/07. Review of the hospital policy and procedure, titled "Documenting the Nursing Process", identified that the interdisciplinary plan of care communicates the plan to manage the patient's specific care needs-including clinical conditions and/or the disease process.

17. Based on a review of clinical records, staff interviews and review of hospital policy, the facility failed to ensure that documentation in the clinical records were complete and/or accurate for Patients # 135, 165, 168, 169, 172 and 178. The findings include:

a. Patient #135 was admitted to the hospital on 7/3/07 with a diagnosis of pneumonia and a past medical history of muscular dystrophy. Review of RN #18's nurse's note dated 11/22/07

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identified that the patient was observed with a 1.5 centimeter (cm) by 0.5 cm area of skin breakdown on the coccyx area with a Duoderm dressing applied. Review of RN #18's documented wound assessment on the patient's flow record dated 11/22/07 indicated that the patient had a stage one (1) pressure ulcer located on the coccyx with a Duoderm dressing applied. Review of the clinical record with the Nurse Manager on 12/4/07 identified a discrepancy in the wound assessment and was unable to determine from review of the clinical record dated 11/22/07 whether the patient had a stage one (1) or a stage two (2) pressure ulcer.

b. Patient #169 was transported to the Emergency Department on 10/19/07 at 5:05 P.M., via ambulance, was triaged as a level 2 with the complaint of out of control behavior (was in a fight) at a residential treatment program and was diagnosed with aggressive behavior. Patient #169's medical and psychosocial histories included mood disorder, impulse control disorder, a twelve-year history of violence towards self and multiple failed placements. Review of the medical record identified that Patient #169 was discharged to the residential treatment program at 9:30 A.M. and at 10:22 A.M. Interview with the Emergency Department Nurse Manager, on 12/7/07, identified that Patient #169 was discharged at 10:22 A.M. and the discharge time of 9:30 A.M. was inaccurate.

c. Patient #168 was admitted to the Emergency Department on 5/23/07 at 10:55 P.M., triage level 3, with the complaint of abdominal pain and no bowel movement for the last five days. Patient #168's medical history included rectal cancer, status post colostomy and ileoconduit (in 2003) and current chemotherapy regime. Review of the physician orders, dated 5/26/07, written by PA #1 and review of the progress notes, dated 5/25/07 at 9:00 A.M. by PA #1, identified that the orders were dated inaccurately. Interview with PA #1, on 12/6/07, identified that he wrote the orders on 5/25/07.

d. Patient #172 was admitted to the hospital on 11/14/07 with the diagnosis of breast cancer and past medical history of hypertension, hypothyroidism, and chronic low back pain. On 11/14/07 Patient #172 had a right total mastectomy and reconstruction with muscle-sparing free transverse rectus abdominis myocutaneous flap, a left breast mastopexy, exploration of right internal mammary vessels with removal of a rib segment, and abdominal wall reconstruction, that started at 8:19 A.M. and ended at 11:01 P.M. Patient #172 was discharged home on 11/20/07 and was re-admitted to the hospital on 1/8/08 with the diagnosis of a retained foreign body in the right breast. Additionally Patient #172 had surgery on 1/8/08 to remove a retained sponge and insertion of two drains then was discharged to home on 1/9/08. Review of the Discharge Summary, dated 1/9/08, identified the inaccurate past medical history that Patient #172 had a left mastectomy on 11/14/07 (had a left mastopexy), inaccurate dates twice in the hospital course and treatment section-regarding the first postoperative date-written as 1-907 (was 1-9-08) and the discharge date-written as 1-1-07 (was 1-9-08), and the discharge medications listed were not comprehensive -missing were an anxiolytic medication, a thyroid hormone and an antihypertensive medication.

e. Patient #178 was admitted to the ED on 1/7/08 at 6:45 AM for acute exacerbation of schizoaffective disorder with delusions. Physician orders dated 1/7/08 at 7:15 AM directed Ativan 1 milligram (mg) by mouth now and Zyprexa Zydis 10mg by mouth twice a day first

dose now. Although the nurse initialed the medication orders as "done" at 7:45 AM, nursing narrative dated 1/7/08 at 8 AM conflicted with this documentation and noted that the patient had refused morning medication and the one time dose of Ativan.
ED nursing documentation for Patient #178 dated 1/7/08 at 12:05 PM identified that the patient was awaiting transfer to the psychiatric hospital. In addition, nursing narratives dated 1/7/08 reflected that the patient became very threatening toward staff and the patient was subdued, medicated, and restrained at 4:45 PM per physician orders. The narrative indicated that the patient received intramuscular (IM) Ativan 1mg, Prolixin 5mg and Cogentin 1mg. The narrative failed to reflect the time that the narrative was written. The medication administration record (MAR) failed to include the IM medications that the patient received. Interview with Pharmacist #1 on 2/11/08 identified that administered medications were documented on the MAR. In order for the MAR to reflect that the medications had been administered, the nurse needed to enter the administered medications into the computer and this had not been done. The hospital History and Progress Notes form identified that all clinical notes must be dated and timed.

f. Patient #165 was admitted to the facility 8/15/07 with Congestive Heart Failure exacerbation and to rule out a Pulmonary Embolism. The patient had a past medical history that includes Diabetes, Gastroesophageal Reflux Disease, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, hypertension and renal insufficiency. Review of the ED order sheet dated 8/15/07 directed that the patient be administered Aspirin 325 mg times one. Review of the ED documentation failed to indicate that the Aspirin had been administered.
In addition, the order indicated that intravenous Heparin be started however, the order failed to indicate a bolus dose and/or infusion rate. Review of the clinical record failed to contain documentation that the Heparin had been administered and/or clarification of the order or discontinuation of the order.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (d) Medical records (3) and/or (e) Nursing service (1) and/or (h) Dietary service (1) and/or (i) General (6).

18. * Based on clinical record review, staff interview and review of facility policy, the facility failed to ensure that nutritional recommendations were followed for Patients #110, 123 and 156. The findings include:

a. Patient #123 had been admitted into the facility on 11/28/07 with diagnosis that included Fever of unknown origin and S/P a renal transplant, pancreatectomy and splenectomy. Review of the nursing physical assessment dated 11/29/07 identified that the patient had an unstageable pressure ulcer on the sacrum. Review of the initial nutritional assessment by RD #3 dated 11/29/07, identified that the patient had protein calorie malnutrition with albumin, poor intake and weight loss. RD #3's recommendations on this assessment, included a multivitamin to meet the patients estimated micronutrients needs, especially with the sacral ulcer, and to consider checking the B12/folate to evaluate the elevated MCV. Review of the medical record on 12/3/07 failed to identify that these recommendations were communicated to the physician.
Interview with the RD #3 on 12/3/07 identified that the patient had been classified III A, which

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indicated a protein calorie malnutrition. She identified that to the best of her knowledge, she had verbally conveyed her recommendations to the team that would have included the intern. Review of the Nutritional plan of care dated 11/29/07 identified that the nutritional consult had been completed and placed in the history & physical section. Review of the nutritional classification and assessment facility policy for Class III A patients directed that two copies of the full nutritional assessment and recommendations be made, one to be placed chronologically in the History & Progress note section of the medical record and the other in the dietician's notebook.

b. Patient #156 was admitted to the hospital on 5/15/07 with a PICC line infection. Patient #156 had a previous anoxic brain injury and also had an unstageable pressure sore that was community acquired. Review of admission dietary consults dated 5/17/07 identified that the patient's weight was 187 lbs with interventions to obtain a weight weekly. Further interventions included Diabetisource at 90cc an hour with 840cc of additional water to meet maintenance fluid needs. Review of the dietary consults dated 6/27/07-11/16/07 identified that the patients albumin level was 1.7 (low) 8/07 and 1.6(low) 10/07. Further review identified that Patient #156 had no weight taken until 11/16/07 (5 months later) at which time a weight of 233 pounds was identified (gain of 46 lbs). Review of hospital policy identified that when patients are classified as having a Stage IV pressure sore, a dietary evaluation is to be completed within 48 hours, with follow-up evaluation every 2-7 days after, depending on medical stability. Interview with the Assistant Director of Dietary on 12/6/07 identified that an assessment of weight is to be included in the dietary evaluation.

c. Patient #110 was admitted to the hospital on 11/15/07 for a cardiac biopsy related to amyloidosis and was identified with a Stage II pressure ulcer on admission. Review of the clinical record identified that a nutritional assessment had been completed on 11/16/07 that indicated that the patient had an Albumin of 1.4 (normal range 3.5-5), an ideal body weight of 74 kg and was protein calorie malnourished (PCM), had poor intake and poor fitting dentures. The dietician recommended daily weights, lab work and an appetite stimulant. The nutrition progress note dated 9/21/07 indicated that the patient's weight on 9/20/07 was 63.6 kgs, a 10.4 kg weight loss. The patient remained on tube feedings of Diabetisource at 70 cc's per hour. The nutrition note dated 9/26/07 indicated that the patients weight on 9/26/07 was 55.1 kg, a total weight loss of 18.9 kgs. Review of the clinical record on 11/28/07 identified that the dietician had not seen the patient again during the period of 11/17/07 through 11/28/07 and that a calorie count had not been completed. Review of the facility policy identified that when a patient is identified as a Class IV, a two-day calorie count should be completed, the chart and intake and output should be monitored every other business day and the Dietician should document progress at least every seven days. Interview with the Director of Dietary identified that the patient should have been seen ideally every seven days. Subsequent to surveyor inquiry, the patient was re-evaluated on 11/29/07 and started on tube feedings.

The following are violations of the Regulations of Connecticut Stage Agencies Section 19-13-D3 (c) Medical staff (4)(A) and/or (e) Nursing service (1) and/or (i) General (6) and/or (l) Infection control (1)(A).

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19. Based on observation, review of medical records, review of hospital policy and staff interview, the facility failed to ensure that infection control practices were consistently implemented. The findings include:

a. Patient #114 was admitted to the hospital on 11/14/07, via the Emergency Department, with the diagnosis of a right hip infection in a surgical site. The patient's medical history included status post right hip fixation, impaired cognition, hemodynamic instability with cardiac arrhythmia, Diabetes Mellitus, electrolyte abnormalities, altered range of motion and Vancomycin Resistant Enterococcus in the right hip wound. Observation of care provided to Patient #114, on 11/29/07 by RN #5, identified that during dressing changes RN #5 contaminated clean dressing supplies and gloves by throwing the items onto a soiled bed, failed to wash her hands between glove changes and failed to secure (tie) the isolation gown in place while providing care to the patient. Review of the hospital clinical practice manual, titled "Open Wounds, Care of the Adult Patient with", identified that between glove changes if the hands are visibly soiled hand hygiene must be performed. Interview with RN #5, on 11/29/07, identified that she was not aware of the reasons for her actions-contamination of gloves and supplies, failure to wash her hands and failure to secure the isolation gown while providing patient care.
In addition, during the observation of care of Patient #114, a volunteer entered the patient's room without any personal protection equipment. Interview with the Nurse Manager of the Unit, on 11/29/07, identified that all visitors that enter patient's rooms, who are on isolation, are required to use the appropriate personal protection equipment.

b. Patient #158 was admitted to the hospital on 11/29/07 with fever, headache and a Urinary Tract Infection. Patient #158's medical history included a renal transplant. Patient #158 was on contact precautions for MRSA and VRE. During tour of the 6-7 unit on 11/29/07 Medical Resident #1 was observed to take an isolation gown and gloves from rack, proceed to put gown and gloves on, drop one glove on the floor, put the glove on and walk into Patient #158's room with a team of other residents and the attending MD. Interview with Medical Resident #1 identified that he was not touching the patient however, interview with Nephrology Attending MD #30 identified that the resident should have put on a new glove prior to entering Patient #158's room.

c. Patient #102 was admitted to the hospital with Cardiac Dysrhythmia. Observation of the patients dressing change on 11/28/07 identified RN #20 changing the dressing to the right knuckle with clean gloves. RN #20 then proceeded to change the dressing on the right forearm using the same gloves from the first wound dressing. Further review identified that RN # 20 had silvadene ointment on her gloves which was the treatment for the dressing to the right knuckle area. Review of the hospital clinical practice manual, titled "Open Wounds, Care of the Adult Patient with", identified that glove changes are to be completed between each wound dressing change and hand hygiene must be performed. Interview with the Nursing Educator on 11/28/07 identified that RN # 20 should have changed her gloves and washed her hands before going on to the next dressing change.

d. Patient #156 was admitted to the hospital on 5/15/07 with a PICC line infection. Patient #156 had a previous anoxic brain injury and was admitted with an unstageable sacral pressure ulcer.

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On 12/5/07, observation of Patient #156's wounds indicated that the patient had a healing Stage III to the sacral area measuring 6cm X 4.5cm, right heel 2.5cm X 2cm, left heel unstageable area 2.5cm X 2cm, and Stage IV to the right hip measuring 2.5cm X 3.5cm X 3.5cm with 4cm of undermining. Observation of RN # 39 during the dressing changes on 12/5/07 identified that the nurse never washed her hands between each dressing change.
In addition, further observation identified that RN # 39 had completed the patients sacral wound dressing change and then proceeded to suction Patient #156 after applying sterile gloves over her contaminated gloves then continue to start the dressing change to the right hip area. Review of hospital clinical practice manual, titled "Open Wounds, Care of the Adult Patient with", identified that glove changes are to be completed between each wound dressing change and hand hygiene must be performed. Interview with the Nursing Director of Medicine on 12/5/07 identified that gloves are to be changed between dressing changes.
In addition, observation of Patient #156 on 12/5/07 identified that the patient was on a Clinitron Rite-Hite Bed. Further observation identified that the bed cover was heavy soiled with body fluids and betadine. Review of the work order dated 10/3/07 identified that the patient was placed on a Rite Hite Bed. Interview with the Nursing Director on 12/5/07 identified that the bed covers can be changed as needed. Interview with RN # 40 identified that she did not know the last time that Patient #156's bed and/or bed cover was changed. Interview with the Bed Manufacturer's Customer Service Manager on 12/12/07 indicated that Patient # 156's bed was last switched out was on 10/3/07 and further indicated that any bed can be switched out at any time if they are soiled by the manufacturer.

e. During observation of a surgical procedure on 11/28/07 in OR #9, the circulating RN was observed on numerous occasions removing and reapplying gloves without the benefit of washing his hands. During the count portion of this procedure, the RN was observed counting the dirty sponges and disposing of them, then proceeding to remove his gloves and documenting in the patient record. Observations further identified the RN proceeding to apply another pair of gloves and assisting with transferring the patient from the OR table to the gurney. Review of the facility's Hand washing standard directed that hand washing be performed after gloves are removed, and at other times as necessary or as required by the performance of clean or sterile procedure.

f. Observation of several operating room associates cleaning the OR's following procedures on 11/28/07 and 11/29/07, identified that they had large and/or multiple unconfined earrings. Review of the facility Surgical attire and dress code policy directed that all jewelry should be confined or removed.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical staff (2)(B) and/or (4)(A) and/or (d) Medical records (3) and/or (7) and/or (e) Nursing service (1) and/or (i) General (6).

20. Based on review of the clinical record, review of hospital policy and procedures and interviews, the facility failed to appropriately implement a discharge plan for Patient #169 and/or failed to communicate to the receiving facility the disposition and/or discharge plan for Patient #170. The

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findings include:

a. Patient #169 was transported to the Emergency Department on 10/19/07 at 5:05 P.M., via ambulance, was triaged as a level 2 with the complaint of out of control behavior (was in a fight) at a residential treatment program and was diagnosed with aggressive behavior. Patient #169's medical and psychosocial histories included mood disorder, impulse control disorder, a twelve-year history of violence towards self and others and multiple failed placements. Review of the medical record identified that on 10/20/07 Patient #169 was discharged to the residential program, although documentation was lacking that the hospital staff communicated to the receiving facility the hospital course and/or other pertinent clinical information regarding Patient #169's status. Interview with the Emergency Department Nurse Manager, on 12/7/07, identified that there is that no discharge instructions were completed for this patient, there is no documentation that hospital staff communicated Patient #169's hospital course and/or status to the receiving facility. Review of the Hospital Bylaws, updated on 9/19/07, identified that the physician is obligated to document and communicate to the receiving caregiver/physician necessary information. Review of the hospital Emergency Department policy and procedure, titled "Patient Discharge and Follow-up Care", identified that patients that are transferred to another facility for treatment require a document (W10) to communicate to the receiving facility the Emergency Department treatment and interventions completed. The hospital Emergency Department policy and procedure, titled "Assessment of Patients", identified that at time of discharge all assessments are documented and the assessment is communicated to the patient and/or the patient's usual caregiver. In addition review of the hospital policy and procedure, titled "Discharge/Transfer of Non-Emergent Patient to Another Health Care Facility for a Lower Level of Care", identified that the nurse providing care will communicate to the receiving facility the patient's hospital course and condition on discharge, pertinent clinical information and transportation information.

b. Patient #170 was admitted to the hospital on 8/29/07 with pneumonia and exacerbation of Chronic Obstructive Pulmonary Disease (COPD). Review of the clinical record identified that the patient resided at Residential Treatment Facility #1 with a plan for the patient to return to this setting upon discharge. Review of the clinical record with Case Coordinator #1 (on 12/6/07) identified that on 9/7/07 the physician requested that the patient be discharged with nursing and drug rehabilitation services as an outpatient. The Case Coordinator identified that she discussed this plan with RN #16 and requested the nurse fax the Inter-agency (W-10) report and Discharge Summary to the Home Care Agency prior to the patient's discharge. Review of the clinical record and interview with RN #16 (on 1/2/08) identified that she contacted the Visiting Nurse Association on 9/7/07 as instructed by Case Manager #1, discussed the plan of care with the nurse at VNA and faxed the W-10 and Discharge Summary to the agency. Interview with RN #16 identified that although she attempted to reach Residential Care Facility #1 prior to the patient's discharge from the hospital, the telephone rang and rang and she and the patient both were unable to connect with a staff member at the facility. The clinical record identified that Patient #170 was discharged from the hospital on 9/7/07 at 6:59 PM and transported back to Residential Treatment facility #1 via taxi service. Interview with Case Coordinator #1 (on 1/16/08) identified that this discharge was treated as if the patient was going home and that no

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policies are in place for a patient being discharged to a Residential Care facility.

21. Based on review of the clinical record, review of the Hospital Bylaws and staff interview, the hospital failed to provide documentation on Patient #169's status to the receiving facility. The findings include:

a. Patient #169 was transported to the Emergency Department on 10/19/07 at 5:05 P.M., via ambulance, was triaged as a level 2 with the complaint of out of control behavior (was in a fight) at a residential treatment program and was diagnosed with aggressive behavior. Patient #169's medical and psychosocial histories included mood disorder, impulse control disorder, a twelve-year history of violence towards self and others and multiple failed placements. Review of the medical record identified that on 10/20/07 Patient #169 was discharged to the residential program, although documentation was lacking regarding the patient hospital course and/or other pertinent clinical information for receiving facility. Interview with the Emergency Department Nurse Manager, on 12/7/07, identified that there is no documentation that hospital staff communicated Patient #169's hospital course and/or status to the receiving facility. Review of the Hospital Bylaws, updated on 9/19/07, identified that the physician is obligated to document and communicate to the receiving caregiver/physician necessary information

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical staff (4)(A) and/or (d) Medical records (3) and/or (e) Nursing service (1) and/or (i) General (6).

22. * Based on clinical record reviews, review of facility policy and documentation and staff interview, the facility failed to provide documentation that sponge counts were done at the time of permanent relief as per policy for Patients #172, 176 and 177. The findings include:

a. Patient #172 was admitted to the hospital on 11/14/07 with the diagnosis of breast cancer and a past medical history of hypertension, hypothyroidism, and chronic low back pain. On 11/14/07, Patient #172 had a right total mastectomy and reconstruction with muscle-sparing free transverse rectus abdominis myocutaneous flap, a left breast mastopexy, exploration of right internal mammary vessels with removal of a rib segment, and abdominal wall reconstruction that started at 8:19 A.M. and ended at 11:01 P.M. Review of the Perioperative Plan of Care dated 11/14/07, identified that RN #22 was the circulating nurse at the start of the surgical case and RN #21 was the permanent relief and was the circulating nurse at the end of the surgical case, although documentation was lacking that RN #22 and RN #21 completed sharps and sponge counts at the time of permanent relief. Interview with the Clinical Instructor of Perioperative Services and Clinical Coordinators #1 and #2 on 1/23/08 and 1/24/08, identified that at the time of permanent relief the sharps and sponges are counted and there was no documentation of counts completed for this patient's case at the time of permanent relief. Review of the hospital policy and procedure, titled "Counts: Sponges, Sharps and Instruments", identified that "Counts are performed to ensure that unintended foreign bodies are not retained", all counts will be performed by the circulator and scrub personnel, the counts will be

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documented on the Perioperative Plan of Care and sharps and sponge counts are performed with permanent relief. In addition, hospital documentation, titled "Goals of the Circulating Nurse", identified that the circulating nurse's role is to safeguard the patient and to verify the accuracy of the sharps and sponge counts. According to the Association of Perioperative Registered Nurses (AORN) "Recommended Practices for Sponge, Sharp and Instrument Count", 2003, documentation on the patient's intraoperatvie record should include, but is not limited to, the results of all surgical items counts.
In addition, review of the South Operating Room schedule from 1/20/08 to 1/23/08, identified that ten cases involved nursing staff permanent relief. A five case review chosen from this sample, identified that documentation in two of the five cases (Patient's #176 and 177), failed to identify the sharps and sponge counts were documented at the time of permanent relief.
Interview with the Clinical Instructor of Perioperative Services and the Clinical Coordinators #1 and #2, on 1/23/08 and 1/24/08, identified that for any incorrect sponge count an event report is completed by the nurse that identified that the count is incorrect. Interview with the Hospital Risk Management Specialist and the Nursing Director of Perioperative Services on 1/24/08, identified that for the incorrect final sponge count that was identified at the conclusion of Patient #172's 11/14/07 surgery, an event report was not completed. Interview with RN #22 on 3/3/08, identified that an event report was not completed. Review of the hospital policy and procedure, titled "Counts: Sponge, Sharps and Instruments", identified that an event report is completed for any incorrect count.

23. * Based on clinical record review, review of facility policy, review of facility documentation and staff interviews, the facility failed to ensure that sponge counts were correct postoperatively for Patient #133, who subsequently required additional surgery to remove a retained sponge. The findings include:
    a. Review of Patient #133's clinical record identified that following admission to another acute care facility on 10/8/07 with a history of vomiting, weight loss, dysphasia, hematemesis and low chest pain, the patient was identified on 10/15/07 with a retained gauze or surgical synthetic mesh or possible tape marker. Patient #133 was transferred back to this facility on 10/16/07 with a diagnosis of a possible Small Bowel Obstruction. Review of MD #33's operative note dated 10/16/07 identified the postop diagnosis of a retained surgical laparotomy pad with duodenal perforation and obstruction. Review of the intraoperative report dated 5/28/07 identified documentation that RN #23 and RN #24 completed the final count and that the count was correct.
    Interview with MD #33 on 1/23/08 at 9AM identified that it was standard procedure that the circulator and the scrub tech do the sponge count twice and report it to the MD prior to closing.

    MD #33 identified that when she performed the exploratory laporatomy on Patient #133 on 10/16/07, a laparotomy pad compressed to half the size, was found deep in the part of the body where the gallbladder and the ducts are posteriorly underneath the liver.
    Interview with RN #23 on 1/23/08 at 9:35AM regarding Patient #133's initial surgery on 5/28/07, identified that Patient #133's surgery had been booked as a Laparoscopic

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cholecystectomy but was converted into an open laparotomy which required the use of additional sponges and instruments that would have been added to the field. RN #23 identified that based on the documentation in the clinical record, the sponge count was correct at the end of Patient #133's procedure. Although RN #23 identified that she and the RN #24 followed the facility's protocol for sponge instrument count, she was unable to explain how Patient #133 had retained a sponge.

Interview with RN #24 (scrub tech) on 1/23/08 at 10AM, identified that Patient #133 required the addition of extra sponges and instruments during the procedure. Although RN #24 stated that she and RN #23 followed facility policies for the sponge/instrument count, she was unable to explain Patient #133's retained sponge, and that her role was to keep track throughout the procedure of any counts on her field.

Review of the facility count policy identified that counts are performed to ensure that unintended foreign bodies are not retained. It directed that all counts should be performed by the circulator and scub person together, visually and verbally and that it would be documented on the Perioperative Plan of Care.

Review of facility documentation dated 11/16/97 identified that changes had been made to the sponge count policy in August of 2007 and that the OR staff had been inserviced.

Interview with the Clinical Instructor of Perioperative services on 1/28/08 identified that inservicing had only included all nurses and surgical technologist in the Main OR which included the ambulatory area and the pedi OR only.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical staff (4)(A) and/or (d) Medical records (3) and/or (e) Nursing service (1) and/or (i) General (6).

24. Based on clinical record review and review of facility policy, the facility failed to ensure that PACU assessments were completed prior to Patient's #115, 117 and 120's discharge. The findings include:
    a. Patient #115 had a surgical procedure on 11/29/07. Review of the Pediatric PACU form identified that the patient had been admitted into the PACU at 8:25AM and discharged at 10:30AM. Review of the Recovery Score documentation on this form, failed to identify an assessment for consciousness, activity, respiration, and oxygenation for the period of 1 hour after admission into the PACU and at discharge as per facility policy.
    b. Patient #117 had an open reduction nasal fracture procedure on 11/28/07. Review of the PACU form identified that the patient had been admitted into the PACU at 1:15 PM and had been there for ½ hour at the time of this record review. Review of the Response observation score area on the PACU documentation failed to identify an assessment score at the time of admission into the PACU and 30 minutes after admission as per facility policy. Review of the facility PACU record policy directed that all patients be scored on admission and every 30 minutes thereafter for the first 2 hours, and then every 1-hour thereafter or more frequently as needed. It directed that all patients must have a score done and recorded at the time of discharge.
    c. Patient #120 had an endometrial ablation procedure on 11/30/07 at the Temple Recovery Center Review of the PACU nursing record identified that the patient had been admitted into PACU at 11:43 AM and discharged to home at 12:45 PM. Review of the Discharge criteria area on this

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form failed to identify assessments for vital signs, ambulation, nausea/vomiting, pain, and bleeding for the 30 minute interval following admission to this unit as per policy. Review of the facility PACU policy/protocol, directed that all patients would have a modified Aldrete score consisting of these 5 components, on admission, at thirty minutes following admission, and at discharge.

The following are violations of the Connecticut General Statutes Section 19a-127n and/or the Regulations of Connecticut State Agencies Section (b) Administration (2).

25. * Based on clinical record reviews and interviews with facility personnel for 2 of 2 sampled patients (Patient's #21 and 83), the facility failed to report pressure sores as an adverse event according to the General Statutes of Connecticut Section 19a-127n. The findings include:

a. Patient #21 was admitted to the hospital on 6/26/07 with a lumbar spinal fracture. Review of the nursing admission assessment dated 6/26/07 identified that the patient's Braden score was a 12 (high risk for pressure sores) with skin intact. Review of the nursing flowsheets dated 6/26/07 identified that the patient had a blister in skin fold below the surgical incision dressing. On 7/3/07, the area was described as a deroofed blister to the left skin fold measuring 1.5cm X 6cm with necrotic edges. Review of the progress notes and nursing flowsheets dated 6/27/07-7/20/07 identified that the patient had an unstageable pressure sore to the sacral/coccyx area. Review of the operative reports dated 7/8/07 and 7/20/07 identified that the patient had a pressure sore to the sacral/coccyx area that was surgically debrided. Review of the nursing care plan dated 7/10/07 identified that the patient had a debrided wound measuring 12cm X 5cm X 4cm. Although interview with MD # 20 on 10/1/07 identified that he had documented for several weeks that the patient had a Stage IV pressure sore, MD # 20 indicated that he later changed the diagnoses to a necretizing infection to the skin fold area. In addition, review of the nursing flowsheets dated 8/13-8/15/07 identified Patient #21 had an unstageable wound to the coccyx area. Observation of Patient # 21's wounds on 8/15/07 with the Wound Care Nurse identified that the patient had a Stage IV wound to the back area measuring 2.5cm X 12.5cm X 1.75cm, a necrotic area to the right buttock area and multiple Stage II's with macuration on the surrounding buttock and sacral area measuring 12.5cm X 10cm. Interview and review of facility documentation with the wound care nurse on 10/1/07 failed to identify that Patient #21's pressure sore was reported to the state agency. Further interview with the wound care nurse on 10/1/07 identified that unstageable wounds are not reported to the state agency.

b. Patient #83 was admitted to the hospital on 5/6/07 after a motor vehicle accident. Patient #83 sustained a traumatic brain injury and multiple fractures including a left tibia/fibia fracture. Review of the admission nursing documentation identified that the patient's skin was intact and the Braden score was 9 (very high risk for pressure sores). On 6/8/07, the patient was identified to have a Stage I red area without breakdown to the right upper buttock/hip. On 7/17/07, Patient #83 had unstageable areas to the left lateral and medial ankle, left outer ankle, left inner ankle, and right buttocks/coccyx areas. Review of the wound consultant noted dated 8/6/07 identified that the patient had a Stage II to the

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sacral/coccyx area 0.5cm and a Stage II to the left buttock 1.5cm X 2cm, left lateral ankle 1.5cm X 2cm with yellow slough and the left medial ankle 0.5cm X 1.5cm with separating eschar. Interview and review of facility documentation with the wound care nurse on 10/1/07 failed to identify that Patient #83's pressure sore was reported to the state agency. Further interview with the wound care nurse on 10/1/07 identified that unstageable wounds are not reported to the state agency.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical staff (4)(A) and/or (d) Medical records (3) and/or (g) Pharmacy (1) and/or (i) General (6).

26. * Based on clinical record review and interviews for Patient #4, the Hospital failed to provide documentation that the patient received the appropriate medication. The findings include:

a. Patient #4 was admitted on 2/6/07 with multiple infected open areas and a change in mental status. On 2/7/07 at approximately 7 AM, Patient #4 was noted to be unresponsive with a blood glucose level of 24. A code was called, Dextrose was administered and the patient became more alert. The patient was transferred to the intensive care unit for stabilization and monitoring of glucose levels. Psychiatry and Neurology departments were consulted due to possible mental status changes as a result of the unresponsive episode and low glucose level. By 2/9/07, the patient's mental status had returned to baseline and following treatment for unrelated illnesses, the patient was discharged back to a long-term care facility.

Following the unresponsive and hypoglycemic episode, staff identified that Patient #4 received 30 units of NPH Insulin on 2/6/07 at 10 PM in error. Interview with Intern #20 on 8/16/07 at 10:10 AM identified that on 2/6/07, Intern #1 inadvertently ordered Insulin for Patient #4, one order to administered Insulin in the AM and one order for the PM. The Intern immediately recognized the error and discontinued two Insulin orders, not noticing that there were three orders. The computerized medication order system had automatically generated a third medication order and the Intern only discontinued two, which left the Insulin 30 units PM order. Intern #1 identified that she was aware of the computer generating a third order and did not realize that all three orders were not discontinued. Interview with RN #20 on 8/16/07 at 1:05 PM identified that on 2/6/07 she received an order to administer Insulin to Patient #4. RN #20 reviewed Patient #4's clinical record that revealed a history of Diabetes, the patient was on a diabetic diet and had a care plan for hyper/hypoglycemia. Based on the record review, RN #20 identified the Insulin order was consistent with the patient's diagnosis and administered the Insulin as ordered.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical staff (2)(B) and/or (d) Medical records (3) and/or (e) Nursing service (1) and/or (g) Pharmacy (1) and/or (i) General (6).

27. For Patients #15, 16, 17, 18, 32, 56 and 57, who were receiving intravenous fluids and/or

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medications, the following was observed:

a. During a tour of the 9-West unit on 8/14/07, the intravenous fluid tubing for Patient #15 and #16 was noted to be outdated (8/9/07). Further observations during the facility tour identified that the intravenous tubing for Patients #15, #17, #18, #32, #56, and #57 was noted to be undated and/or untimed and was not maintained in accordance with the facility policy which requires that intravenous tubing be changed after seventy-two hours.

b. During a tour of the 9-7 unit on 8/13/07, Patient #17 was observed with an unlabelled 1000 milliliters (ml) bag of Sodium Chloride 0.9% infusing at a rate of 100 ml per hour. Physician's orders dated 8/13/07 included "IV bolus with 0.9% Sodium Chloride, 1000 ml, run as quickly as possible". Review of the medical record with the 9-7 Nurse Manager identified that the physician's orders were incomplete and lacked documentation that the physician had been notified. The Nurse Manager stated that the standard is to label the bag when it is initiated and that the ordering physician had been notified to clarify the order; however, failed to enter the verified rate of 100 ml per hour into the computer physician order entry.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (c) Medical staff (2) (B) and/or (d) Medical Records (3) and/or (e) Nursing Service (1) and/or (i) General (6).

28. Based on review of the clinical record, review of facility policies, and interviews, the facility failed to ensure Patients #88 and 89, who required emergency services, were monitored in accordance with facility policies. The findings include:

a. Patient #88 arrived in the ED on 8/13/07 and was triaged at 2:15 PM. Patient #88 reported complaints of right lower quadrant pain radiating to the back. Review of the ED admission record lacked documentation to reflect the time that Patient #88 was seen by the physician or the time of the physician order that directed monitoring of the patient's blood pressure hourly. The documentation identified that Patient #88's blood pressure was obtained at the time of triage (2:15 PM) and not obtained again until 9:52 PM, more than seven hours later. Interview with the ED Nurse Manager on 8/14/07 identified that ED policies directed that if patient volume kept triaged patients in the waiting room, vital signs would be obtained a minimum of every four hours. In addition, Patient #88's ED documentation identified that a Normal Saline lock (intravenous access line) was inserted into the patient's left forearm at 9:53 PM. Review of the ED physician order sheet lacked documentation of a physician order for the Normal Saline lock.

b. Patient #89 arrived via ambulance in the ED on 8/13/07 after being found unresponsive after ingesting an illegal substance. Patient #88 was triaged at 8:07 PM where it was identified that the patient received Narcan, an antidote for the illegal substance, prior to the ED arrival. Review of the handwritten physician order sheet lacked documentation to reflect the time of the physician order entries that directed vital signs, an electrocardiograph (EKG), and the insertion of a Normal Saline lock.

In addition, interview with the ED Nurse Manager on 8/14/07 identified that Patient #89 was discharged from the ED at 11:17 PM on 8/13/07. Review of the ED admission record identified that the patient's vital signs were last obtained at 9:15 PM, more than two hours before

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discharge. Interview with the ED Nurse Manager on 8/14/07 identified that ED policies directed that vital signs be obtained within one hour of discharge.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical records (3) and/or (e) Nursing service (1) and/or (i) General (6).

29. For Patients #9 and 34 identified with alterations in skin integrity, the facility failed to perform an accurate assessment of the patient's skin integrity and/or develop a comprehensive plan of care to address the patient's risk for skin breakdown. The findings include:
    a. Patient #9's admission assessment dated 3/15/07 at 10:10 p.m. identified that the patient was at very high risk for the development of pressure ulcers. The nursing flow sheet identified pressure ulcers and an abrasion to the patient's scrotum. Although treatment was provided in accordance with the Clinical Management Protocol, review of the medical record on 8/20/07 with the Wound Care Consultant identified that a complete assessment of the area, inclusive of measurements, was not provided until 3/16/07 at 11:30 a.m. Further review identified that the medical record lacked a plan of care to address the patient's alteration in skin integrity and potential risk for skin breakdown. The facility Clinical Management Protocol for pressure ulcers identified that the location, stage, and size of the pressure ulcer are documented. A plan of care must be developed for at-risk patients and interventions are listed on the Interdisciplinary Plan of Care.
    b. Patient #34's diagnoses included Parkinson's disease and the patient was admitted to the facility on 5/16/07. The Braden Scale risk assessment dated 6/5/07 identified that the patient was at high risk for the development of pressure ulcers and preventive measures were initiated. The Patient Care flowsheet dated 6/21/07 identified a 2 x 3 Stage II area on the coccyx; however, lacked the increment of measurement used and/or complete documentation of the area until 6/22/07. Nurses' notes dated 6/22/07 identified a Stage II area on the left Coccyx (2 cm x 1 cm) and a Stage II area on the right coccyx (2 cm x 1 cm). Although Patient #34 was noted to have two Stage II areas, nursing flow sheets dated 7/28/07 to 7/30/07 identified one Stage II area. Review of the medical record dated 6/21/07 to 8/13/07 on 8/20/07 with the Director of Wound Care Management identified discrepancies in the accuracy of Patient #34's skin integrity assessments, which were not performed in accordance with the facility protocol. The facility Pressure Ulcer Prevention and Treatment policy identified that all patients' skin is assessed daily and documented on the Patient Care Flowsheet. If the patient has a pressure ulcer, the location, stage, size, and ulcer bed color is documented. Measurements are completed in centimeters (cm).

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (d) Medical records (3) and/or (e) Nursing service (1) and/or (i) General (6).

30. For Patient #33, the facility failed to revise the plan of care to address the patient's change in behavior. The findings include:
    a. Patient #33's diagnoses included alcohol and cocaine dependence and suicidal ideation.

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Nurses' notes dated 8/13/07 identified that Patient #33 had a verbal/violent outburst and the patient was restricted to his room at that time. Nurses' notes dated 8/14/07 at 7:00 a.m. identified that the patient was again agitated and was made aware that he was room restricted. Review of the medical record on 8/14/07 with the 9-5 Nurse Manager identified that it lacked documentation that a room restriction was initiated. The Nurse Manager stated that the intervention should have been added to the interdisciplinary plan of care. In addition, the facility lacked a policy regarding Room Restriction.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical staff (2)(B) and/or (d) Medical records (3) and/or (e) Nursing service (1).

31. Based on review of the clinical record, review of facility policies, and interviews, the facility failed to ensure that Patient # 8's medical record contained all pertinent information related to the patient's refusal of services. The findings included:
    a. Patient #8 was brought to the Emergency Department (ED) on 6/13/07 at 9:45 AM by a family member, Person #1. Patient #8 reported blurry vision and unsteady gait after reportedly ingesting twelve Xanax tablets at approximately 6:00 PM the evening before. The clinical record identified that Patient #8 denied homicidal or suicidal ideation, had a self reported history of illegal substance abuse, and reported that he had taken the Xanax "to get high." Review of the clinical record identified that MD #5 ordered an Electrocardiogram (EKG), blood work that included an "Over Dose (OD) panel", and urine toxicology screening. Review of the clinical record identified that after medical clearance, Patient #8 was discharged home at 1:10 PM with Person #1. Review of the discharge instructions signed by Patient #8, identified that Patient #8 was given written information regarding his substance abuse that included encouraging the patient to join recovery groups and/or programs related to the substance abuse. Interview with Person #1 on 8/17/07 identified that she was upset that Patient #8 had not been seen by Social Services and/or had specific referrals arranged in connection with the patient's ingestion of the Xanax. Interview with Patient #8 on 8/24/07 identified that the patient was unable to recall details of the 6/13/07 ED visit. Interview with MD #19, the ED Medical Director, on 8/27/07 identified that MD #5 reported that he had offered additional services to Patient #8 but that the patient refused. Review of the ED admission record lacked documentation to reflect that counseling and/or other services were offered and/or refused by Patient #8.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical records (3) and/or (e) Nursing service (1) and/or (i) General (6).

32. Based on clinical record review and interview for Patient #3 who was discharged from the Emergency Department, the Hospital failed to provide for the patient's needs at the time of discharge. The findings include:
    a. Patient #3 was admitted to the Emergency Department on 5/8/07 at 8:59 AM after making homicidal statements at a long-term care facility. The patient was medically cleared and

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referred to Psychiatry for an evaluation. The patient was seen by APRN #20 who determined the patient was not a danger to self or others and was safe for discharge. The patient could not return to the long-term care facility, so APRN #20 contacted a shelter and the patient was discharged to the shelter at 3:55 PM. Review of the clinical record identified that staff failed to identify how the patient was to get to the shelter, failed to make provisions for the patient to obtain prescribed medications, and failed to arrange for follow-up services. Interview with APRN #20 on 8/15/07 at 11:35 AM identified that after Patient #3 was assessed as being safe for discharge, the APRN contacted a shelter, secured a bed, and the patient was discharged with money for a cab ride to the shelter. APRN #20 identified that the clinical record did not reflect that cab fare was provided to transport the patient to the shelter. In addition, APRN #20 identified that provisions were not made for the patient to obtain his medications following discharge and provision for follow-up care was not identified. According to the patient discharge and follow-up care policy, at the time of discharge, specific individualized instructions are given pertaining to follow-up care for each patient.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D (d) Medical records (3) and/or (e) Nursing service (1).

33. Patient #1 presented to the Emergency Department on 7/11/07 at 11:55 PM with an open chest wound after sustaining a fall at home. Review of the clinical record with MD #2 on 8/1/07 identified that the patient had a ten (10) to fifteen (15) centimeter soft tissue defect located beneath the left nipple region of his chest that required sutures. MD #2 further identified that based on the patient's past medical history of chronic headaches, encephalopathy, dizziness and unsteady gait, a neurological evaluation was ordered. Review of the neurological examination dated 7/12/07 identified the patient had word finding difficulties, memory impairment, was paranoid, very suspicious and would not allow a comprehensive examination at that time. A recommendation for a psychological evaluation to determine competency and admission to the hospital for a complete medical work-up was made. Review of the psychological evaluation dated 7/12/07 identified Patient #1 had severe cognitive impairment and was too severely ill for detailed cognitive testing. Patient #1 was admitted to the hospital on a Physician's Emergency Certificate (PEC) and was placed on constant observation during the period of 7/12/07 through 7/17/07 due to a flight risk. Review of the clinical record identified that on 7/12/07, MD #3 prescribed antipsychotic medications to address the patient's psychosis. Review of the record identified that the patient refused this medication on 7/13/07, 7/15/07 and 7/18/07 and that the numerous diagnostic tests that were ordered to work-up the patient medically were also refused (genetic testing, lumbar puncture) by the patient. Additionally, review of the clinical record indicated that the patient refused assessment and/or prescribed treatments to his chest wound on 7/13/07, 7/14/07, 7/15/07, 7/16/07 and 7/17/07. Review of the nursing care plan with the Nursing Director on 8/1/07 failed to identify that the care plan addressed the patient's intermittent refusal of medications and/or treatments of the chest laceration and/or elopement risk requiring constant observation and/or frequent refusals for diagnostic testing.

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The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D (b) Administration (2) and/or (e) Nursing service (1).

34. Patient #45 was admitted to the hospital on 8/11/07, via the Emergency Department after an unwitnessed fall was diagnosed with a right intertrochanteric fracture and had a right hip replacement on 8/12/07. Patient #45's medical history included dementia, coronary artery disease, breast cancer, hypertension and chronic renal insufficiency. During an interaction with Patient #45, on 8/14/07, a staff member identified a sign posted on the right side of the overhead light, for Patient #45, that identified the patient's medical diagnosis of dementia, a telephone number of the assisted living facility that the patient resided prior to admission and directions to call the facility for patient information. Interview with the Nurse Manager of the 7-7 unit, on 8/14/07, identified that she was unaware that the identified sign was posted in Patient #45's room and removed the sign on 8/14/07. Additionally interview with RN #6, on 8/14/07, identified that the identified sign had been in place on 8/12/07 during the 7:00 A.M. to 3:00 P.M. shift and was unaware who posted the sign.

The following are violations of the Regulation of Connecticut State Agencies Section 19-13-D (b) Administration (2) and/or (c) Medical staff (2)(B) and/or (4)(A) and/or (d) Medical records (3) and/or (i) General (6).

35. Patient #6 was admitted to the hospital on 11/22/05 via the Emergency Department after being found at home without a pulse and not breathing and was diagnosed with anoxic brain injury after cardiopulmonary arrest from an overdose. Patient #6's medical history included polysubstance abuse. Review of the progress notes from 12/12/05 to 12/31/05 when Patient #6 resided on unit 5-7, identified sixteen entries that Patient #6 received care in two inaccurate locations e.g. in the Women's Center and at the Adult Outpatient Care Center. Interview with the Nursing Director of Medicine on 8/21/07, identified that the identified inaccuracies were the result of using the incorrect template during transcription.
Additionally, review of the clinical record identified that Patient #6 received general anesthesia for surgical interventions on 1/23/06 and 3/16/06. Documentation failed to identify that the anesthesia staff completed a follow up visit following the two surgeries. According to the American Society of Anesthesiologist it is the anesthesiologist's responsibility to complete a post anesthetic evaluation.

36. Patient #42 was admitted on 6/29/07, with the diagnoses of respiratory distress, premature birth, tracheomalacia, status post lysis of bowel adhesions and gastric feeding tube. Review of the clinical record identified that Patient #42 received general anesthesia for surgical interventions on 7/3/07, 7/11/07 and on 8/8/07. Documentation failed to identify that the anesthesia staff completed a follow up visit following the three surgeries. Interview with the Nursing Director of Pediatrics on 8/13/07 identified that the anesthesia department completes a patient follow up twenty-four hours after the patient's surgery. Interview and chart review with MD #11, the Director of Pediatric Anesthesia on 8/13/07, identified that there is no documentation that the

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anesthesia staff completed a follow up visit with this patient following the three surgeries and the follow up should be completed twenty-four hours after the patient's surgery. According to American Society of Anesthesiologist it is the anesthesiologist's responsibility to complete a post anesthetic evaluation.

37. For four (4) of four (4) clinical records reviewed of patients that had a Cesarean Section procedure, Patients #10, 35, 38 and 39, the facility failed to provide documentation that an anesthesia post-operative follow-up had been completed. The findings include:

a. Patient #10 was admitted on 8/6/07 with flank pain and fever. The patient's history included hyperemesis and hypertension. On 8/7/07 the patient was consented to have a C-Section (Cesarean Section) secondary to fetal distress. Review of the anesthesia record identified that the patient had been administered a spinal anesthetic. Review of the record on 8/13/07 identified that the patient was being discharged to home and lacked documentation by anesthesia follow-up post operatively.

b. Patient # 35 was admitted on 8/10/07 and verbally consented to have a C-Section procedure. Review of the Anesthesia record identified that the patient received a spinal as the anesthetic. Review of the record on 8/14/07 identified that the patient was discharged home and that the record lacked documentation by anesthesia post operatively.

c. Patient # 38 was admitted on 8/11/07 in active labor and with elevated blood pressures. Consent for a C-Section procedure had been obtained after the diagnosis of Cephalo-pelvis disproportion secondary to staging. The anesthesia record identified that the patient received an epidural bolus for labor. Review of the labor record identified that the epidural tip was intact when removed by anesthesia at 10:25 AM. Review of the record on 8/14/07 lacked documentation by anesthesia post operatively.

d. Patient # 39 was admitted to the labor and delivery on 8/10/07 to rule out ruptured membranes. The record identified that the patient received an epidural for an emergent C-Section procedure secondary to fetal bradycardia. Review of the anesthesia record identified that anesthesia start time was 7 AM and ended at 10:19 AM and that the epidural removed at 11:03 AM. Review of the record on 8/14/07 identified that the patient had been discharged home and lacked documentation by anesthesia post operatively. Interview on 8/21/07 at 1 PM with the Chief of Anesthesia identified Guidelines for Patient Care in Anesthesiology that directed postanesthetic care when a patient remains in the hospital postoperatively for 48 hours or longer that one or more notes should appear in the addition to the discharge note from the postanesthesia care unit.

38. For one (1) of two (2) consent forms reviewed for patients between the age of 8 through 14, the facility failed to ensure that Patient #38's consent form was signed by an adult eighteen years or over for a surgical procedure and /or the administration of blood products. The findings include:

a. Patient # 38 was admitted on 8/11/07 in active labor and with elevated blood pressures. Review of the consent form for the C-Section procedure for the diagnosis of Cephalo-pelvis disproportion secondary to staging identified that the minor patient had signed the form.

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Additionally, review of the permission for operation or special procedure dated 8/12/07 identified that the minor patient had signed this consent form for blood transfusion. Review of the record identified documentation that the patient's mother was present and in the room with the patient. Interview with the Director of Women and Infant Services identified that the patient would be considered an emancipated minor and could make decisions about the pregnancy. Evidence of emancipation was not identified in the record. Review of the facility Consent for operation or other procedure policy identified that the age of majority is 18 and under most circumstances parental consent is required for treatment of minors. The policy further identified that a minor may consent to pregnancy-related care for themselves without the consent of parents.

The following are violations of the Regulation of Connecticut State Agencies Section 19-13-D (c) Medical Staff (2)(B) and/or (d) Medical record (3).

39. For Patients #27 and 52 surgical records that were reviewed, the facility failed to provide documentation that the history and physical (H&P) was completed and updated within thirty (30) days prior to surgery. Based on review of the medical record, review of the Medical Staff Bylaw Rules and Regulations and interview of facility personnel, the findings include:
    a. Patient #27 underwent a tonsillectomy on 8/13/07. Review of the medical record identified that the H&P had been completed on 5/9/07. Although the H&P had been updated the morning of the surgery, the original H&P had not been completed within 30 days of surgery according to the facility's Medical Staff Bylaw Rules and Regulation.
    b. Patient #52 underwent a repair of an inguinal hernia on 8/14/07. Review of the medical record reflected that although the H&P was updated on the morning of the surgery, the original surgery was completed on 5/17/07. According to the Medical Staff Bylaw Rules and Regulation, an H&P must be less than 30 days old to qualify for updating the day of surgery. If the H&P is older than 30 days, an entirely new H&P must be completed.

The following are violations of the Regulation of Connecticut State Agencies Section 19-13-D (b) Administration (2) and/or (c) Medical Staff (2)(B) and/or (4)(A) and/or (d) Medical record (8).

40. For three (3) of ten (10) surgical records reviewed (Patients #49, 51 and 52), the facility failed to ensure that the anesthesia pre-operative evaluation was complete and/or accurate. The findings include:
    a. Patient #49 underwent the removal of hardware from bilateral arms on 8/14/07. Review of the pre-anesthesia evaluation completed the morning of 8/14/07, identified that the Anesthesiologist failed to document that the risks and benefits of the anesthesia had been discussed with the patient as required on the Anesthesiology Attending Preoperative Assessment.
    b. Review of Patient #51's medical record, identified that the patient had bilateral myringtomy tubes inserted on 8/14/07. Review of the Pediatric Anesthesiology Pre-op Assessment

identified that the date the assessment was completed was 6/29/07. Additionally, the form failed to identify the patient's present illness and lacked the attending Anesthesiologist's signature that the risks and benefits had been discussed with the child's parent.

c. Patient #52 underwent a repair of an inguinal hernia on 8/14/07. Review of the Pediatric Anesthesiology Pre-op Assessment identified that the assessment was completed by an APRN. The attending Anesthesiologist's signature was illegible and the form failed to be dated and timed. Additionally, the form failed to identify the anesthesia plan. According to the American Society of Anesthesiologists, 2005, the preanesthesia evaluation should include, in part, documentation of an appropriate physical examination, an assignment of an ASA physical status and formulation of the anesthetic plan with the discussion of the risks and benefits of the plan with the patient or the patient's representative.

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D3 (b) Administration (2) and/or (d) Medical Records (3) and/or (e) Nursing Service (1) and/or (i) General (6).

41. * Based on review of the medical record, interviews, and review of facility policy for one patient, Patient #2, who subsequently required additional surgery to remove a retained foreign object, the facility failed to ensure that the Intra-Operative Record contained complete and accurate documentation of sponge count assessments and/or failed to ensure sponge counts were performed according to policy. The findings include:

a. Patient #2's diagnoses included rectocele, enterocele, cystocele and stress incontinence. Review of the medical record identified that on 10/16/2006, the patient underwent an anterior and posterior vaginal repair with mesh augmentation by MD #17. Review of the Intra-Operative Record dated 10/16/06, identified that Surgical Technologist #1 was the scrub person and RN #9 was the Circulating Nurse. The Intra-Operative Record further identified Surgical Technologist #2 and RN #10 as the relief Scrub Person and Circulator. Although a review of the Intra-Operative Record identified that the final sponge count was correct, Patient #2 required additional surgery on 5/17/07 to remove a retained Raytex sponge. During interview on 8/16/07, MD #17 stated that although the surgery was a vaginal approach, multiple cavities, including anterior and posterior, were opened and closed. MD #17 identified that staff reported that the final sponge count was correct. During interview on 8/21/071, RN #9 stated that she was present for the initial count with Surgical Tech #1, however, she was relieved for lunch by RN #10, whom she told to count. RN #9 left the room, handing the data worksheet to RN #10. RN #9 stated a sponge counter was not utilized during the surgery and that the surgery had been completed by the time lunch break was over. The data worksheet was discarded after surgery. During interview on 8/21/07, RN #10 stated that although she counted sponges in the kick buckets visually and verbally with Surgical Tech #1 when she entered the room, RN #9 was not present for the count. Review of the facility policy identified that all counts should be performed by the circulator and scrub person together, visually and verbally, sponge counters should be used on all cases requiring more than ten sponges and that all nursing personnel involved in the case should be present together at the time of counting when a permanent relief occurs.

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Review of Patient #2's intra-operative record dated 10/16/06, identified that the procedure was completed between 9:50 AM and 12:06 PM and that the "final count" was correct as completed by RN #10 and Surgical Technologist #1. The record failed to identify when other counts had occurred and by which staff. During interview on 8/21/07, the Director of Perioperative Services stated that all surgical count documentation, except for the final count, was eliminated from the Intra-Operative Report due to the need for space reduction. Although the count information, including participants and type of count, could be retrieved from the computer, this information was not part of the medical record. According to the AORN Recommended Practices for Sponge, Sharp and Instrument Count for 2003, documentation on the patients Intra-Operative Record should include, but not limited to, results of surgical item counts.

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D3 (b) Administration (2) and/or (f) Diagnostic and therapeutic facilities and/or (i) General (6).

42. Review of the ESRD (end-stage renal disease) water testing documentation for the acute Dialysis Unit on 8/15/07, identified that the test completed on June 29, 2007, reflected that the central reverse osmosis (RO) water tested high for fluoride at 0.2830 (acceptable level 0.0-0.2000). Review of the facility documentation identified that the facility failed to retest the water on the central RO upon receipt of the high fluoride count. During interview on 8/21/07, the Facility Administrator stated that the water should have been retested when the reading of high fluoride was received. She stated that consequently the RO water was retested on 7/30/07.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical Staff (4)(A) and/or (e) Nursing (1) and/or (g) Pharmacy (1) and/or (i) General (2) and/or (6) and/or (l) Infection Control (1).

43. During tour of WP-4 on 8/13/07, the nutritional refrigerator was observed to contain a bottle of Maalox. Additionally, this refrigerator failed to have a thermometer to ensure the proper temperature was being maintained.

44. During tour of the Maternal Special Care Unit on 8/13/07, two of the unoccupied patient rooms were observed to have soiled refrigerators. Interview with the Clinical Manager of the unit identified that once the patients had been discharged the refrigerators should have been cleaned.

45. Observation of the Cardiac Care Unit nourishment room on 8/13/07 at 10:45 AM, identified that the refrigerator door's magnetic strip was hanging from the bottom of the door. In addition, the floor underneath and directly in front of the refrigerator was heavily soiled with a build-up of a black sticky substance. Interview with the Patient Service Manager and Clinical Service Manager on 8/13/07 identified that the floor should be cleaned on a daily basis.

46. Observation of Unit 5-2's nourishment room on 8/13/07 at 2 PM, identified that the interior of the

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refrigerator was heavily soiled with a build-up of a black sticky substance. Interview with the Patient Service Manager and Clinical Service Manager on 8/13/07 identified that the refrigerator should be cleaned on a daily basis.

47 The autoclave's monitoring log in the Labor and Delivery area used in the "flashing" of instruments was noted to lack consistent documentation for incubation biological read-outs for the dates of 7/10, 8/10 and 8/12/07.

48. During tour of the Temple Surgical Center Operating Room #3 on 8/17/7, a personal bag was observed on the OR floor during the time the OR was being set up for a case.

49. During a tour on 8/13/07 of the treatment room on the Pediatric Intensive Care Unit (PICU), it was observed that four syringes of Fentanyl (an opioid analgesic) and six syringes and three multiple dose vials of Versed (an anxiolytic) were unattended and unsecured on the top of and/or in the first drawer of a stand. Although the room had a key code access, interview with the Nurse Manager of the PICU on 8/13/07, identified that licensed and unlicensed staff have the key code access to the treatment room.

50. A tour of the Central Sterile Department on 8/15/07 identified an open window between the decontamination and clean processing areas. The window was manually closed in the surveyor's presence. The Supervisor stated that a malfunction of the equipment had occurred and that the company would be notified. A Service Call Report identified that the problem was addressed on 8/16/07.

51. Review of scope cleaning procedures in the GI Suite (gastro-intestinal) on 8/15/07 identified a gluteraldehyde daily testing and change-out log for 8/07. Further review failed to identify testing logs prior to 8/07. During interview on 8/15/07, the Manager of the Unit stated that daily testing was performed and that she was unaware that a log needed to be maintained to demonstrate the solutions' integrity.

52. During tour of the West Pavilion OR on 8/14/07, it was observed that the OR tech failed to use a clean mop head and clean water for cleaning of the OR floor between cases. During interview on 8/14/07, the OR tech stated that he utilized a mop head for "a few cases" and changed the water when "it became dirty". Review of the facility policy for Infection Control/Perioperative Services identified that a new disposable mop head should be used for each room and that the used germicidal solution should be disposed of in the janitor's sink.

53. During tour of the South Pavilion OR #8 on 8/13/07, a personal brief case was observed to be on the OR floor adjacent to the anesthesia machine. Although the surveyor requested the facility policy governing use of personal belongings within the operating room arena, the facility failed to have such a policy.

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54. Observation during tours of all operating room pavilions on 8/13/07 and 8/14/07 identified numerous operating room personnel failed to have their hair contained within a cap. In all cases observed, a skull cap was noted to be worn which failed to cover the hair on the sides of the head and at the nape of the neck. According to the facility policy for Surgical Attire and Dress Code, complete coverage of the hair is necessary including sideburns and hair at the nape of the neck. Skull caps that fail to cover those areas should not be worn in the semi-restricted and restricted areas of the surgical suite.

55. During tour of the East, South and West Pavilion operating rooms (OR) on 8/13/07 and 8/14/07, several fluid warmers utilized for semi-rigid irrigation container warming were observed with temperatures documented as high as 122 and 126 degrees Fahrenheit. Review of the facility policy for Warming of Solutions identified that the temperature of irrigation solutions in semi-rigid pour bottles should range from 98 to 110 degrees Fahrenheit.

56. During tour of the South Building Cysto Room on 8/13/07,steris trays were observed stored on the floor. According to the facility policy for Infection Control/Perioperative Services, clean supplies should be stored above the floor level on shelves and/or in the cabinets.

57. During a tour of the outpatient emergency department on 8/15/07, the following was identified:
    a. The Broselow cart was noted to contain an expired intravenous start kit (Expiration 10/06) and two expired endotracheal intubation kits (Expirations 4/07 and 5/07).
    b. One dozen green-topped blood collection tubes were noted in the clean utility storage area with an expiration date of 6/07.

58. During tour of the NICU on 8/14/07, it was observed that a triple lumen catheter site rite machine was dated to be checked by 7/07 for a safety check. Review of hospital policy identified that safety checks of equipment are performed every 6 months. Interview with hospital personnel on 8/14/07 identified that safety checks were not completed in the time frame specified by policy.

59. During tour of the NICU on 8/14/07, it was observed that a code cart was not checked for safety on a daily basis. Review of the emergency equipment checklist sheets dated 7/07-8/07 identified on multiple days the emergency equipment was not checked. Interview with the NICU Nurse Manager on 8/14/07 identified that the emergency equipment checks are to be completed on a daily basis.

60. During a tour of the Cardiac Catheter Laboratory/Interventional Radiology on 8/16/07, multiple rooms were identified that contained keys in the unlocked cabinets which contained multiple vials of lidocaine, epinephrine, atropine and syringes. Observation of Room 2-318 identified medications (Lidocaine, Bicarbonate and Heparin) on a stretcher without licensed personnel present. One room was observed to not have any locks on the doors. Review of hospital policy identified that medications are to be stored in a locked area and secured from unauthorized personnel. Interview with the Nurse Manager of the Cardiac Catheter lab on 8/16/07 identified that all medications needed to be locked and secured. In addition, the Nurse Manager identified that a

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purchase order was completed to have locks installed on the medication cabinets.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical Staff (4)(A) and/or (d) Medical records (3) and/or (i) General (6).

61. * Patient #132 was admitted on 11/16/07 for an open reduction of the right elbow and external fixation. Review of the Anesthesia record identified that Anesthesia care team #1 started with the procedure at 9:20AM and ended at 4:15PM. Anesthesia care team #2 was identified as taking over with the procedure at 4:15PM but an ending time failed to be documented in the space provided. The record further identified that the patient was on spontaneous volume and in sinus rhythm between 4:30PM and 4:45PM. At 4:40PM, the patient was extubated with a tidal volume of 500cc identified. The clinical record failed to identify documentation of the monitoring of the patient for the period between 4:30PM and 4:45PM, and a line was placed across the anesthesia record that identified no oxygen and/or monitors had been placed on transport.

Interview and review of the record on 2/27/08 with MD #40, the Program Director for Anesthesia, identified that the record does not reflect the monitoring of the patient after the extubation, that it was a medical decision to monitor the pulse oximetry or apply oxygen during the transfer from the OR to the recovery area and that the facility had no policy prior to this incident. MD #39 identified that although Resident #2 had not circled nitrous air or air, she believed the patient also received 1.5 of air throughout the surgery.

Interview with Resident #2 identified that when MD #39 came to the bedside, she directed him to intubate the patient. He identified that he saw the laryngoscope go through the vocal cords and had hooked the end of the endotracheal tube to the Ambu bag. He identified that a nurse heard bilateral breathsounds loud and clear.

RN # 25 identified that Resident #2 also listened for breath sounds and said they were everywhere. Resident #2 identified that both he and MD #39 had asked for a CO2 monitoring detector but none was provided. He identified that when there was no improvement to the saturation rates, heart rate or blood pressure, MD #39 decided to pull the endotracheal tube. Resident #2 identified that the patient had been reintubated by another Attending, MD #41. Interview with MD #38 on 2/11/08 identified that CO2 detectors are kept in the anesthesia workrooms. Interview with RN #30 identified that CO2 disposable single use detectors are now placed at every bedside in the PACU.